Mid South Health Initiative

RESOURCE REPORT

Creating Community Environments that Promote Comprehensive Health and Wellness

A Working Conference
Jackson, Mississippi
January 9-10, 2006

Sponsored by the Foundation for the Mid South
Funded by the Robert Wood Johnson Foundation

Mid South Health Initiative
Creating Community Environments that Promote Comprehensive Health and Wellness

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Acknowledgements

The Foundation for the Mid South is committed to improving the quality of life in our communities. We recognize that good health is one of the cornerstones of living a full and productive life. Our commitment to achieving this goal is shaped by the voices of those who have committed their life's work to curing disease and developing disease prevention and health improvement strategies.

The Foundation wishes to acknowledge and thank those who have given up their time and energy to increase our collective understanding of health and poor health status in our three-state region. This Resource Report attempts to reflect the comments and issues of the initial task force convening in June 2005. It adds to their efforts, the thoughtful investigative and analytical work of researchers and staff from three of our finest higher educational institutions: The Office of Community-Based Public Health, University of Arkansas for Medical Sciences; the Mississippi Health Policy Research Center, Mississippi State University; and the Resource Center for Rural and Community Health Improvement, Louisiana State University School of Public Health. The results of these efforts clearly demonstrate that we have the collective wisdom within our three states to make improvements in health status and the quality of life of our citizens.

The Foundation is grateful to its board, the Robert Wood Johnson Foundation, and the Southern Regional Health Consortium (SRHC) which have made this effort possible. The SRHC has provided the knowledge, experience, and insights of its eight member states on making health improvements. SRHC is also responsible for assembling the team to develop this Resource Report.

We also acknowledge the ravaging impact of hurricanes Katrina and Rita on our communities and upon the governmental, educational, religious, and social institutions that we all depend upon. We commit to ensuring that our total recovery is a critical goal of the Foundation for the Mid South; and that this initiative will be a critical part of working toward that recovery.

We especially thank the Task Force that guided the planning of the conference and the organizations across the Mid South for their cooperation in developing this report and for their day to day dedication to improving the lives of all of our citizens.

Necole S. Irvin
Special Projects Officer
Mid South Health Initiatives
January 2006

Introduction

The Foundation for the Mid South is a grant making and program-initiating organization serving Arkansas, Louisiana, and Mississippi. The Foundation was established on the premise that if the Mid South is to solve its problems, it must build from the ground up and from within the region itself. The Foundation works in partnership with communities as they develop long-term strategies to make local improvements and assists communities with identifying tools and information to guide their work. The Foundation's three areas of program focus are education, economic development, and programs for families and children. For a more detailed description of the Foundation for the Mid South, see Appendix A.

The Resource Report: The Resource Report is one of the key tools that the Foundation for the Mid South uses to guide the development of new initiatives (See Appendix A). The Mid South Health Initiative Resource Report was developed in response to the convening of a health task force in June 2005 to be disseminated to invitees for a regional working conference in January 2006. The objectives for this second conference are:

- To introduce the Foundation for the Mid South as a regional partner in improving the health status of the region.
- To learn more about the health status in the three states from participants, and advance a regional approach.
- To use the Resource Report to introduce new approaches to understanding and making health status improvements.
- To disseminate promising practices that address health status problems in the Mid South.
- To encourage collaboration across disciplines and sectors in order to comprehensively address health status problems in the region.
- To engage in dialogue about the catastrophic impact of the recent hurricanes in the Mid South; and to discuss healing responses within the health sector that may also have long term implications for the health system within the region.

Spatial Mapping as a Tool for Analysis. This report will feature a number of maps. Spatial mapping is a new analytical tool that is being utilized in all types of applications including law enforcement, business, marketing, epidemiology, and public health. Data points from a data base are entered into a file and mapped according to zip codes, census tracts, or a relevant spatial classification. Spatial mapping is not intended for identifying geographic points, but to illustrate associations between data and geography.

Most maps in this report will illustrate more than one data type, which will enable associations between factors of interest. For example, one map will illustrate poverty levels in the Mid South in relation to areas heavily populated by African Americans. Spatial mapping can be useful in understanding problems and designing targeted solutions.

The Southern Regional Health Consortium: The Southern Regional Health Consortium (SHRC) is a regional consortium of eight southern states including Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Texas and West Virginia. The SHRC is an outgrowth of the Southern Rural Access Program which was funded by the Robert Wood Johnson Foundation. The SHRC is committed to identifying, quantifying and articulating the root causes of poor health status in the southern region of the United States; and in seeking solutions that address them.

The SHRC is a perfect partner to the Foundation for the Mid South in the development of its Mid South Health Initiative. The SHRC assembled an excellent team of health specialists from institutions of higher learning located within the Mid South Region. This is key to the Foundation's fundamental value that solutions must come from within. The process also has the potential to bring our community collaborators closer to health experts who already have a tremendous commitment to serving their own communities. We hope that the process will cultivate new relationships and lasting partnerships that will result in better informed and more effective community, state, and regional initiatives. Secondly, the SHRC has a proven track record with community health initiatives that have worked and have made an impact in South. Some of these programs are featured as promising practices in this Resource Report.

Most excitedly, the SHRC's leadership recognizes that traditional approaches to treating the symptoms of ill health are not sufficient to move the needle towards improved health status. Members of the SHRC are taking bold steps to examine the root causes of health disparities that plague the region. This report includes a summary of the results of the SRHC's recent efforts to closely examine the literature on health disparities and to develop new community health approaches that can make a decided difference in health status in the future.

It would be an unforgivable omission to convene around health and fail to consider the devastation as well as the opportunity created by hurricanes Katrina and Rita to rebuild and improve upon our health delivery system. There were multiple systems failures that should be examined, and analyzed with respect to the potential to not only repair, but to improve systems in a dramatic way. The development of an electronic medical record system is one such example. Implementation of superior disaster planning and response teams is another.

It is our greatest hope that this report and the adjoining regional conference will be rejuvenating and will accelerate our commitment to working as a regional collaborative to make a difference in the lives of our citizens.

A Prologue

The Katrina – Rita Disaster

Prologue
The Katrina - Rita Disaster

On August 29, 2005, Hurricane Katrina swept through the Gulf Coast states of Alabama, Louisiana, and Mississippi leaving a path of destruction that is described as the largest natural disaster in the history of America. On September 24, 2005, twenty-six days later, Hurricane Rita swept through southwest Louisiana and east Texas, further ravaging the homes and lives of another million people residing in these areas; and compounding the already shattered lives of over 100,000 Rita evacuees who were still seeking shelter after Katrina in some of those same areas. The loss of homes, businesses, jobs, and lives due to Katrina alone has created the largest economic impact compared to any recent natural disasters in America. Between the two storms over 200,000 residents are homeless and many remain and are likely to be permanently displaced across the country.

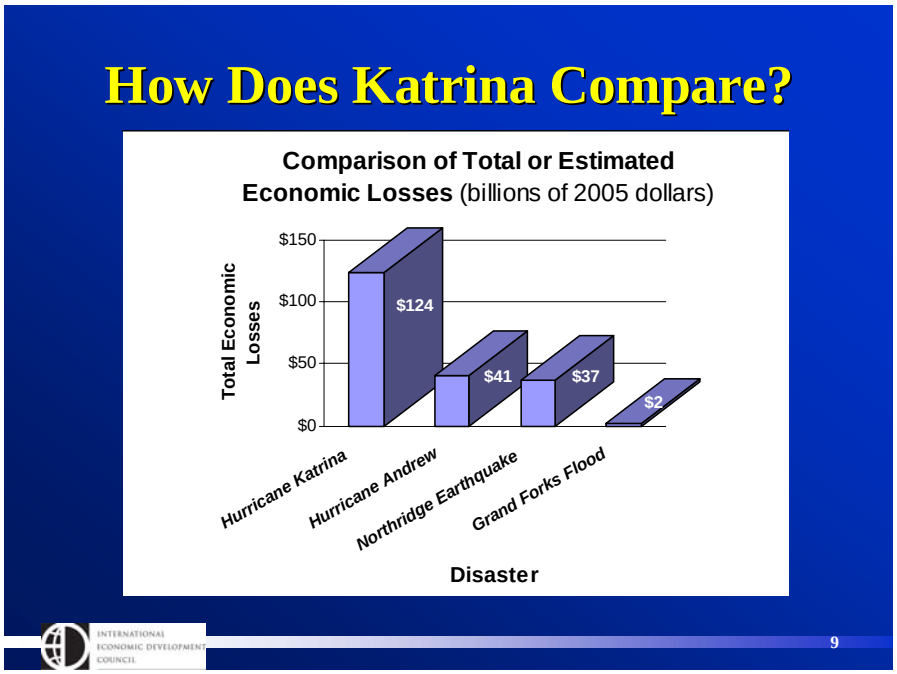


Figure A *Comparison of Economic Impact of Recent Natural Disasters, International Economic Development Council, 2005*

Katrina's impact on individuals, families, and communities will be felt for years to come, and will take time to fully comprehend. The shock waves continue to challenge the brightest minds attempting to manage a complex and delicate recovery process. The challenge of this report is to focus on the impact of these devastating natural disasters on the health delivery system in the Mid South, and on how it may influence the approach and the priorities for the Mid South Health Initiative.

Demographic changes: The Katrina-Rita disaster has resulted in mass displacement of people, dramatically impacting the demographics in Louisiana and Mississippi. According to the Congressional Research Service (CRS) of the Library of Congress, the estimates of the number of people displaced range widely. CRS analysis assumes 700,000 were acutely impacted, Secretary Chertoff has stated that FEMA has sheltered over 600,000 and media

reports cited figures as high as 1.2 million in describing the displaced. At their peak, shelters were housing over 270,000 evacuees, but, as of October 19, 2005 fewer than 8,000 were still in shelters. While some families have already returned home, many are living in interim housing, including FEMA-provided trailers and hotel rooms. FEMA reported that it has approved over 265,000 applications for temporary housing payments and, as of October 19, has provided just under 12,000 trailers (CRS, 2005). Whether these families will eventually return home or resettle in new communities is unclear and will not be fully known until the reconstruction of the Gulf Coast is complete.

We know the demographics in this report are confounded by the massive displacement of humanity from the affected areas. However, despite many agencies' attempts to predict and project the movement of people, jobs, and businesses, this is still a dynamic process which will be difficult to pinpoint for some time.

Impact on Medical Systems and Services: Throughout the Gulf Coast, stories have arisen on the disruption of health care and lack of emergency health preparedness. The storms destroyed medical facilities in storm-affected areas, and there was an acute increase in demand for medical services in the surrounding instate and out of state areas. At least eight hospital facilities were severely damaged in Orleans Parish including the major trauma center for southern Louisiana, and none have reopened. Community health centers and rural health clinics in storm affected areas reported power outages destroying vaccines and other refrigerated medications that were in high demand after the storm. During the immediate wake of these storms, emergency rooms in small rural hospitals were serving 2-3 times the usual patient volume due to a flood of storm evacuees. Most of the patient complaints were not emergencies, but evacuees had to use emergency rooms due to a lack of an established relationship with any local provider.

Electronic Medical Record: On the positive side, the Katrina-Rita disaster raised the urgency and importance of electronic medical records. Records were totally destroyed in some facilities and are irretrievable in countless others. Health professionals had to treat patients without any knowledge of their medical histories as evacuees relocated. There was a litany of Medicare, Medicaid, and other reimbursement questions that arose due to the lack of patient records or the time or capacity to process paperwork. This natural disaster may be the critical experience that could forward the use of the electronic medical record.

Prescription Drugs: Obtaining prescriptions for evacuees was a challenge. Evacuees' doctors were not available to verify illnesses or prescriptions, so local medical personnel had to write new prescriptions. Local pharmacists were provided FEMA support to provide low cost prescriptions, but this led to inventory and cash flow problems. The pharmacy crisis highlighted a second dimension and potential benefit of an electronic medical record system.

Mental Health: The health care system was totally unprepared to address the primary mental health services for storm evacuees, over-stressed host families and relief staff. Thousands of hurricane survivors along the Gulf Coast are now coping with the loss of relatives and friends, homes, and businesses, and "loss of community." For the survivors who lost everything, it involves coping with the stress of starting all over. Two weeks after Katrina struck more than 2,500 children and countless elderly were still separated from their families (Bullard, 2005). One can only imagine the mental anguish these children, seniors and families

experienced. The Katrina and Rita disasters have served to highlight the inadequacies of community mental systems. They are a catalyst for a wave of planning to develop more comprehensive community mental health systems to provide mental health screening in primary care settings, treat depression, and treat post-traumatic stress disorders that are characteristic of natural disasters.

Public Schools: Katrina displaced just under 350,000 school children in the Gulf Coast. An estimated 187,000 school children have been displaced in Louisiana and 160,000 in Mississippi. Katrina closed the New Orleans school system, and the majority of public schools remain closed. More than 125,000 New Orleans children alone are attending schools elsewhere

Churches: Churches were an essential community resource during these catastrophic events. Their flexibility and moral determination made this group the mainstay of hurricane relief. Churches were able to effectively and quickly mobilize volunteers and collect donations. They were the best venue for getting aid directly and quickly to victims. It was the responsiveness and the creativity of churches during hurricane relief and recovery efforts that were unexpected but most refreshing. Churches have emerged as the focus of a new community emergency response model that bears investigation for the future.

African Americans and Poor Bear Disproportionate Burden: Hurricane Katrina has likely made one of the poorest areas of the country even poorer. Among those displaced by the storm, many lost their homes, material possessions, and jobs. Some had insurance to replace their material property losses. Some received FEMA assistance or small business loans to replace property, or received unemployment insurance or disaster unemployment insurance to replace lost wages. However, some who lived in the areas most impacted by the storm may now be destitute and have joined the ranks of the poor.

Further, the socio-economic profile of the areas hardest hit by Katrina indicates that these newly poor would join a population that was already disproportionately poor and disadvantaged. Before the storm, the 700,000 people acutely affected by Katrina were more likely to be poor and minority (most often African-American), less likely to be connected to the workforce, and more likely to be educationally disadvantaged (i.e., not having completed a high school education) (CRS, 2005).

The three states where communities were damaged or flooded by the hurricane rank among the poorest in the nation. According to the 2000 Census, Mississippi ranked second only to the District of Columbia in its poverty rate and Louisiana was right behind it ranking third. The CRS estimated that about one-fifth of the population most directly impacted by the storm was in poverty (21%) - well above the national poverty rate of 12.4% recorded in the 2000 Census. (CRS, 2005)

Generally, emergency responses reflect the pre-existing social and political stratification, with communities of color receiving less priority than Caucasian communities. Equity issues revolve around which community needs are addressed first and which communities are forced to wait. African American disaster victims often receive less support, information, and emotional help than equally affected disaster victims who are Caucasian (Bullard and Wright, 2005). Past studies show that African American disaster victims are more likely to suffer from delayed post-traumatic stress disorder (PTSD) than Caucasians.

Recent news pointed out that African Americans were disproportionately forced to evacuate farther away from home, many relocating to very culturally different communities. This migration is having a significant impact on school-age children. More than 93 percent of New Orleans schools are predominantly African American. Evacuated children are being enrolled in school districts from Arizona to Pennsylvania, including almost 46,500 students who are attending school in Texas (Council of Chief State School Officers, 2005). The long-term impact of this abrupt and traumatic relocation of these children is unknown.

The NBC television network highlighted the difficulties that African American families are experiencing in their relocation efforts. The December 20, 2005 evening news reported alarming results from recent bias testing conducted by the Office of Fair Housing and Equal Opportunity. The Office found that 66 percent of housing inquiries involved racial discriminatory practices indicated favoritism shown towards Caucasians over African American callers. In the case of African American callers, no messages were returned, or Caucasians were given inducements and more information. The Office conducted bias testing in 17 cities and 15 states including Texas, Florida and Alabama.

Studies also show that African Americans are also mistrustful of agencies staffed largely by Caucasians and are less willing to turn for aid. The level of public trust—and for good reasons—differs widely across racial and ethnic groups. A legacy of slavery, "Jim Crow" segregation, institutionalized discrimination, and unequal law enforcement has left Africans Americans displaying greater distrust of the judicial system, the health care system, and toward the government in general (Bullard, 2005).

"Differences in trust reflect divergent experiences of African Americans and Whites. The mistrust of the medical profession and biomedical community dates back to the antebellum period in our nation's history when slaves and freed blacks were used in nonconsensual experimentation. Successful public health response to epidemics and natural disasters will depend heavily on overcoming the historical legacy of suspicion and distrust" (Bullard, 2005, Pg. 1).

Katrina and Rita Assistance:

Health Resources and Services Administration: HRSA has a web site that summarizes federal payments available for providing health care to hurricane evacuees and for rebuilding health care infrastructure. http://www.hhs.gov/katrina/fedpayment.html#1

Foundation for the Mid South: The Foundation for the Mid South is maintaining a recovery fund and has a grant program to assist in the recovery process. http://www.fndmidsouth.org/Katrina_Recovery_Fund.htm

Robert Wood Johnson: The Robert Wood Johnson Foundation created a $10,000,000 hurricane relief effort. Information can be obtained at http://www.rwjf.org/newsroom/featureDetail.jsp?featureID=1006&type=3

Section I:

Mid South Demographics

Arkansas, Louisiana, Mississippi

Section I
A General Profile of the Mid South

The Mid South includes three states, Arkansas, Louisiana, and Mississippi. The Mississippi River is the thread that joins the three states and is the source of the many similarities in this region. For example, all three states have large agricultural business along the Mississippi Delta. All three states produce cotton and soybeans and have similar levels of cattle farming. Aquaculture is common to both Louisiana and Mississippi whereas poultry farming is the largest agribusiness in Arkansas and Mississippi. Louisiana has the largest investment in cotton and is the only state that produces sugarcane, its larges crop. Louisiana is a major American producer of oil and natural gas and is a center of petroleum refining and petrochemicals manufacturing. Arkansas is a world leader in bromine production and is also large in petroleum refining and petrochemicals manufacturing.

Among the three states, Arkansas has the smallest population and the greatest population increase. There are approximately 2,752,629 residents in Arkansas (US Census, 2004Estimate) and its population increased by 14.6 percent from the 1990 Census. The population of Mississippi is approximately 2,902,966 (US Census, 2004 Estimate. Louisiana's population is almost twice that of Arkansas and Mississippi, estimated at 4,515,770 (U.S. Census, 2004 Estimate). Although the population of Louisiana had grown slightly since 1990, hurricanes Katrina and Rita have caused a substantial number of residents to relocate, and the permanency of these relocations is uncertain.

What is most poignant about the Mid South is its dire poverty. Any demographic description will highlight the disproportionate number of families in poverty. The map on page 9 of this report indicate illustrate how African Americans and poor residents are clustered in a clear swath along the Mississippi Delta in all three states.

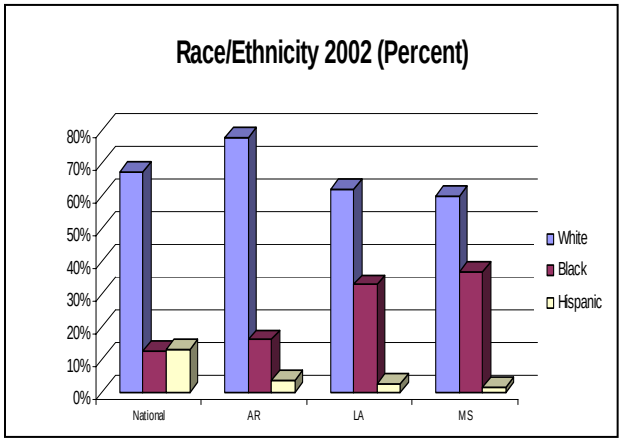


Figure 1.1 *Percent Race by State*

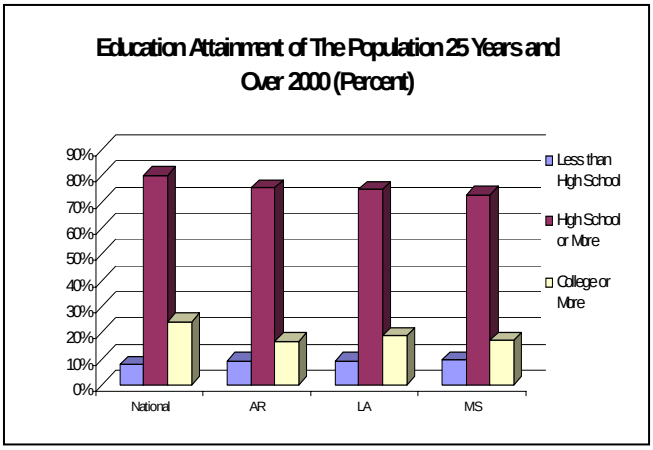


Figure 1.2 *Educational Attainment of Population, Aged 25+ by State*

Educational Attainment: Education is a predictor for economic status and educational attainment is lower in the Mid South compared to the United States. Although nursery school and kindergarten enrollment were similar to national percentages, enrollment in elementary school through college steadily declined for the Mid South. Compared to the national average of 12.1 percent, the percent of students from the Mid South that failed to complete high school averaged 16.2 percent (U.S. Census, 2000). The gap widened for the percent of Mid South residents that attained a bachelor's degree or higher (17.4 % average) compared to national percentage (24.4 %). Percentages of students acquiring an associate degree were also less for the Mid South (4.4 % average) compared to 6.3 percent for the nation (U.S. Census, 2000).

Per Capita Income: In 1999, the three states had an average per capita income of $16,556, which was 76.7 percent of that for the nation. The percent of persons living below poverty for the region (18.4 %) was 6 percent higher than the national average of 12.4 percent (U.S. Census, 2000).

Disability Status: Physical disabilities greatly impact upon the employment status of Mid South citizens. Compared to the nation, a larger percentage of Mid South citizens have disabilities in all age groups, but especially during employable years. Even during their youth (ages 5-20), 9.1 percent of Mid South citizens have disabilities compared to 8.1 percent nationally. For citizens in their productive years (ages 21-64), the disability rate is 23.3 percent for the Mid South compared to 19.2 percent for the nation (U.S. Census, 2000).

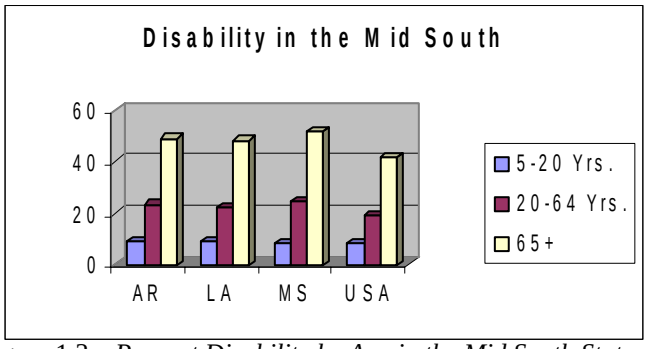


Figure 1.3. *Percent Disability by Age in the Mid South States.*

Families in Poverty and Racial Status: In the United States racial identity is a strong predictor for poverty, particularly for African Americans, Latinos and Native Americans. Two states in Mid South have the largest percentages of African American residents in the nation. The average percent of African Americans residents in Louisiana and Mississippi is 34.4 percent, compared to 15.7 percent for Arkansas and 12.3 percent for the nation. Although the percent of Latinos is growing in the Mid South, the current percent is considerably lower than for the nation.

There is a close association between families living in poverty and racial status in the Mid South. Among the three states, Arkansas has less than half the percentage of African American residents (15.7 %) compared to Mississippi and Louisiana (34.4%). The overall percentage of families in poverty residing in Arkansas is less than in the other two Mid South States; and poverty is concentrated within African American communities in all three states.

The communities of highest density of African American Arkansans live in the south to southeast counties, particularly along the Mississippi River in the Delta Region. This area of Arkansas is highly agricultural and predominantly rural. The poorest parishes in Louisiana are likewise located along the Mississippi River. There are also high poverty levels in north eastern and north central Louisiana; and in the southeastern parishes. The number of families living below the poverty level in Mississippi are also located along the Mississippi River Delta, or the western border of the state.

In these parishes, the relationship between African American families living in poverty is startling. Here, 30 to 50 percent of the residents are African Americans, and 20 to 33 percent of families live below poverty. It is anticipated that Katrina and Rita have permanently displaced a sizable number of poor families in Louisiana and Mississippi, and race and poverty statistics may change or shift over the next few years.

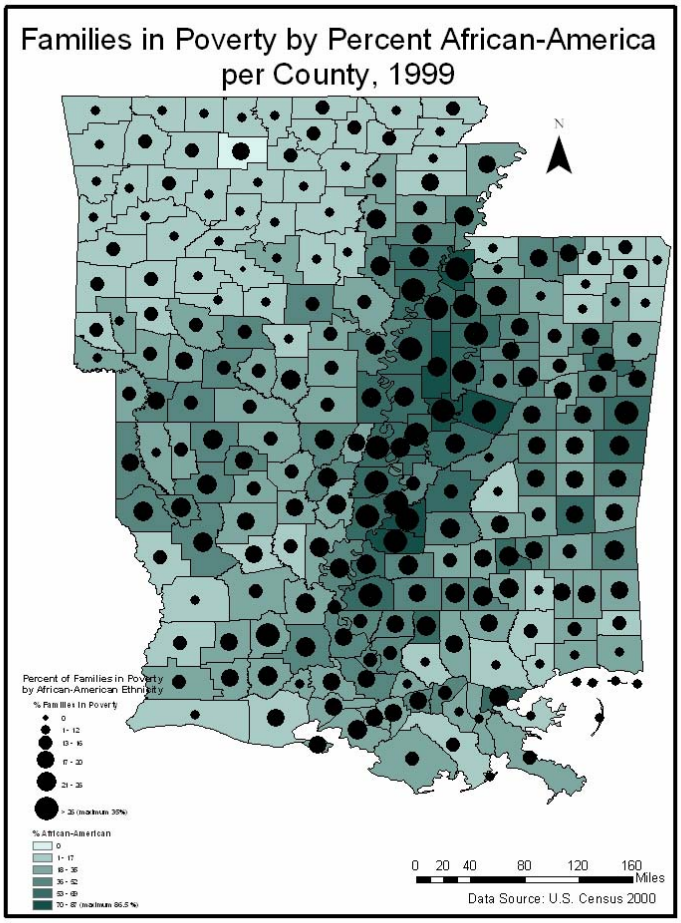


Figure 1.4. *Poverty density compared to locations of African American Communities in the Midsouth, Data Source US Census, 2000.*

Conclusion: The persistent poverty among African American families in the targeted geographic regions compromises the quality of life for these citizens. The implications for designing regional approaches to eradicating poverty and eliminating race-induced inequality are compelling. Later this report will specifically examine how poor health status is directly linked with poor socioeconomic status (SES) and race and racially motivated discriminatory practices.

Section II

Health Status Profile

Section II
Health Status Profile

The Mid South is notable for poor health status. Health status can be measured in a variety of ways. Death or mortality rates are a means of measuring health as well as the presence of disease states or morbidity measures. The three leading causes of death in the Mid South and nationally are heart disease, cancer, and cerebrovascular disease. Rates are relatively similar although Arkansas has the highest mortality rate from cerebrovascular disease; Louisiana from cancer; and Mississippi has the highest rate of mortality from heart disease.

Crude Mortality Rates for Arkansas, Louisiana, and Mississippi			
	Arkansas (2001*)	**Louisiana (2000*)**	**Mississippi (2003*)**
Heart Disease	274.5	286.7	300.6
Cancer	207.6	226.0	205.4
Cerebrovascular Disease	75.8	60.3	62.5

Figure 2.1 *Mortality Rates per 100,000 for Three Top Diseases in Arkansas, Louisiana, and Mississippi * Source: State Health Departments for AL, LA, and MS. Note: Different data collection dates are reported by each state's health department.*

Infant mortality is considered a broad marker for the effectiveness of a state's or nation's health system overall. Generally associated with low-SES, infant mortality rates fall behind the national average for the Mid South, but are substantially worse for Mississippi.

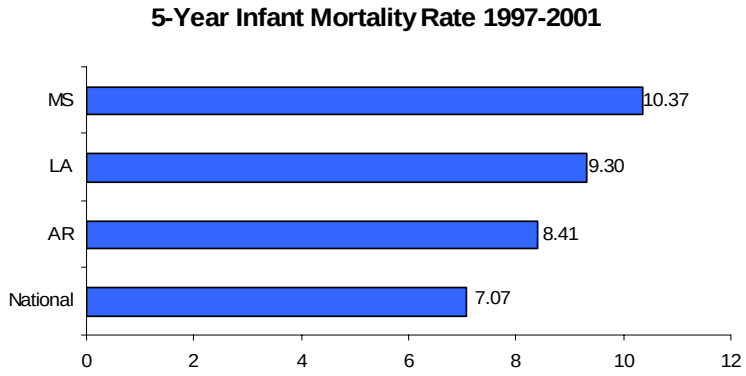


Figure 2.2 *Infant Mortality in the Mid South, Data Source: Area Resource File, 2004.*

Health status also measure by morbidity rates. The HIV/AIDS epidemic, which has become a disease of the impoverished, continues to impact the public health status in the Mid South, and will make significant demands on health resources in future decades. Louisiana's rates are the largest in the Mid South and far exceed the national rates.

AIDS Cases and Rates in Arkansas, Louisiana, and Mississippi, 1998-2000

States	1998		1999		2000	
	Cases	Rate/ 100,000	Cases	Rate/ 100,000	Cases	Rate/ 100,000
Arkansas	203	8	194	7.6	194	7.3
Louisiana	951	21.8	854	19.5	679	15.2
Mississippi	415	15.1	421	15.2	431	15.2
USA	48,269	17.6	46,400	16.7	40,660	14.4

Figure 2.3 *AIDS cases and Death Rates per 100,000 in Arkansas, Louisiana, and Mississippi, Source States' Health Department Data.*

Life Expectancy is another major indicator of health status. Although there have been substantial improvements over the past few decades, life expectancies have lagged behind for African American women and men (U.S. National Center for Health Statistics, 2001).

	WF	WM	BF	BM
1970	75.6	68.0	68.3	60.0
1975	77.3	69.5	71.3	62.4
1980	78.1	70.1	72.5	63.8
1990	79.4	72.2	73.6	64.5
1995	79.6	73.4	73.9	65.2

Figure 2.4 *Life Expectancy at Birth 1970-1999 by Race and Gender. WF=White Female, WM=White Male, BF = Black Female, and BM=Black Male Source: Williams, 2004*

Self-reported information is another valuable tool for evaluating health status and is collected through surveys. The Behavioral Risk Factor Surveillance System (BRFSS), conducted by the Centers for Disease Control and Prevention, is the world's largest telephone survey, that tracks health risks in the United States. Information from the survey is used to improve the health of the American people. Compared to national respondents, residents of the Mid South were considerably less likely to report that their health status was good or better (BRFSS 2003-4).

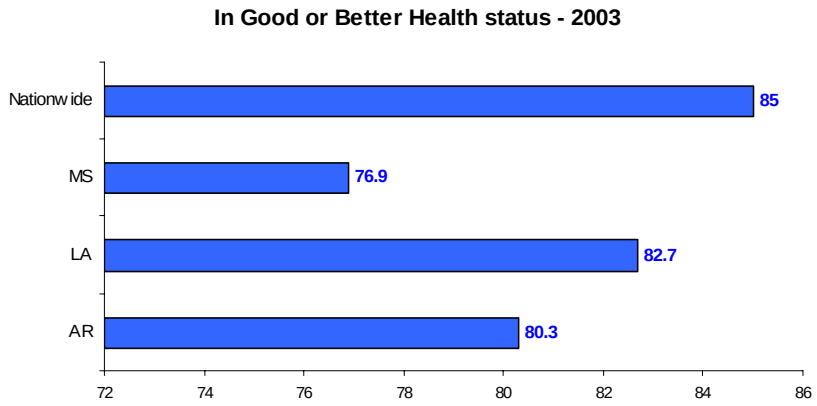


Figure 2.5 *Self-Reported Health Status, Source: BRFSS, 2003*

Access to Care: Over the past several decades, it has been determined that clinical medicine has played a smaller role in improving population health than sanitation, nutrition, and higher living standards. However, access to preventive care and clinical therapy can improve health status, quality of life, and life expectancy. There are social and regional differences with respect to access to care. Socially disadvantaged racial groups and persons of low SES have lower levels of insurance coverage.

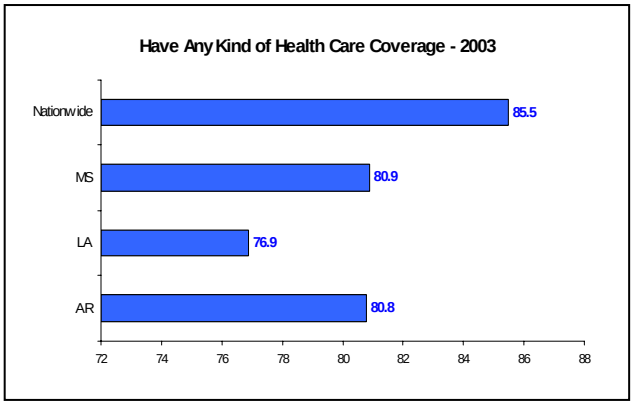


Figure 2.6 *Access to Health Care Coverage, Source: BRFSS, 2003*

Residents of the Mid South reported themselves as less likely to have any type of health care coverage compared to national respondents. This situation may exacerbated by the Katrina-Rita disaster, which has displaced many health providers, businesses and jobs in the area.

Access to Health Facilities and Health Providers: In addition to lacking financial access to medical services, there is also a maldistribution of health providers with fewer providers locating in high need areas. The following map highlights the problem of availability of providers in area where mortality rates are the highest. Medical doctors are more densely located in areas where the population appears to be healthiest.

This is due in part to low socioeconomic indicators that characterize geographic areas of highest need; i.e. providers do not have adequate financial incentives to practice in low SES areas.

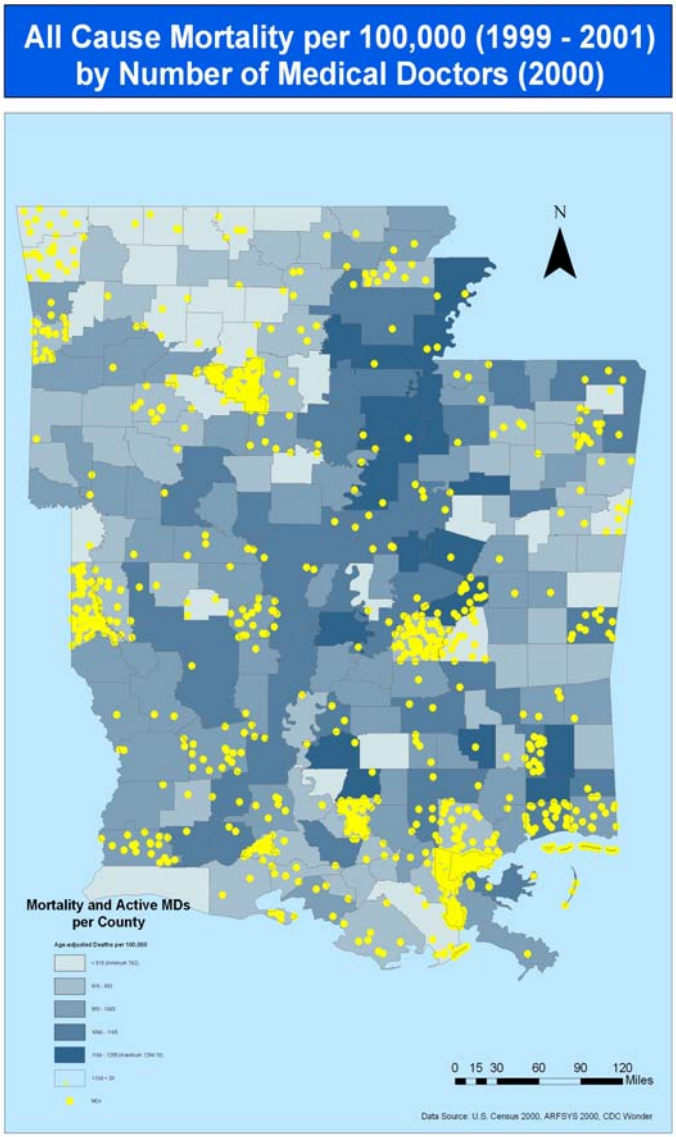


Figure 2.7. *Mortality for all causes per 100,000 in the Mid South, and Availability of Medical Doctors. Source: US Census, 2000*

Another aspect of the maldistribution problem is the over-investment in acute versus primary care, or sick care versus prevention. Although primary care provides the greatest opportunity for early detection and costs saving, significantly more resources are invested in hospital care compared vs. primary care (federally qualified health centers and rural health clinics) especially in Arkansas and in Louisiana. Clearly the opportunities for implementing more effective preventive measures are compromised by this distribution of resources. (See Tables 2.7 and 2.8.)

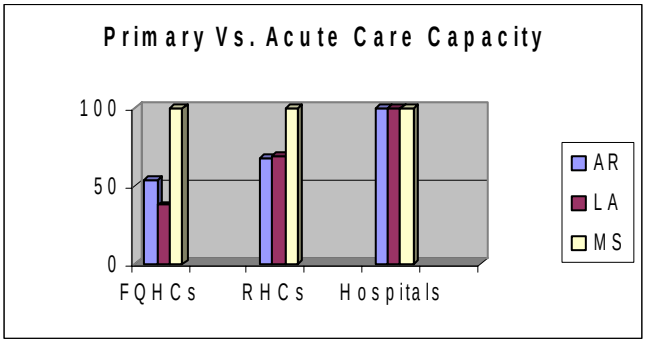


Figure 2.8 *Total Numbers of Federally Qualified Health Centers (FQHCs) Rural Health Clinics (RHCs), and Hospitals in Arkansas, Louisiana, and Mississippi. Source: Bureau of Primary Care, HRSA*

The distribution of resources is clearer in the next table when it is presented as types of facilities per 100,000 population. Here the lower investment in community-based primary care is evident in Arkansas and most dramatic in Louisiana.

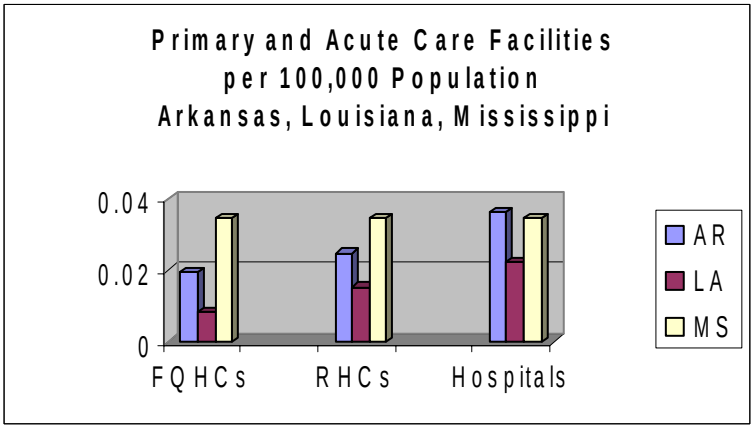


Figure 2.9. *Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs); and Hospitals per 100,000 population in Arkansas, Louisiana, and Mississippi. Source: Bureau of Primary Care, HRSA*

Health Seeking Behaviors: Residents of the Mid South do not take full advantage of screening and other preventive services. In some instances, one of the three states may perform better than the other two, suggesting the opportunity to share best practices across the Region. The following illustration demonstrates the utilization of pap smears among women in the Mid South. Pap smears are a screening exam for cervical cancer as well as cervical abnormalities, infections and sexually transmitted diseases that may affect pregnancy outcomes. Arkansas performs substantially higher than the national average, Mississippi slightly higher and Louisiana substantially lower.

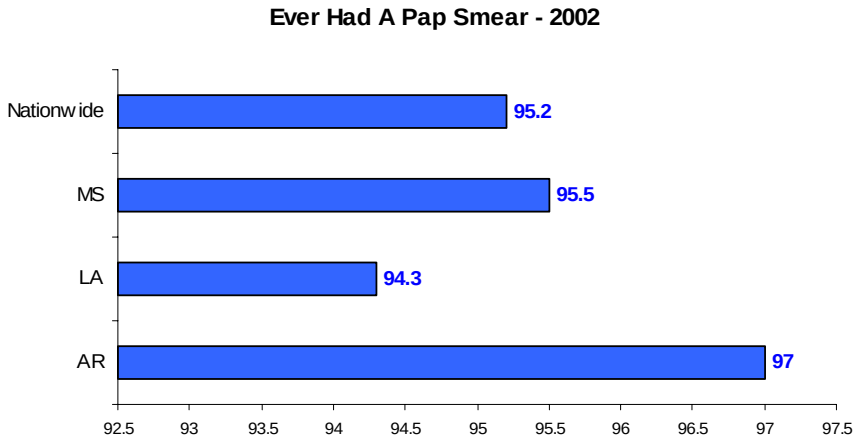


Figure 2.10 *Cervical Cancer Screening in the Mid South, Source: BRFSS, 2003*

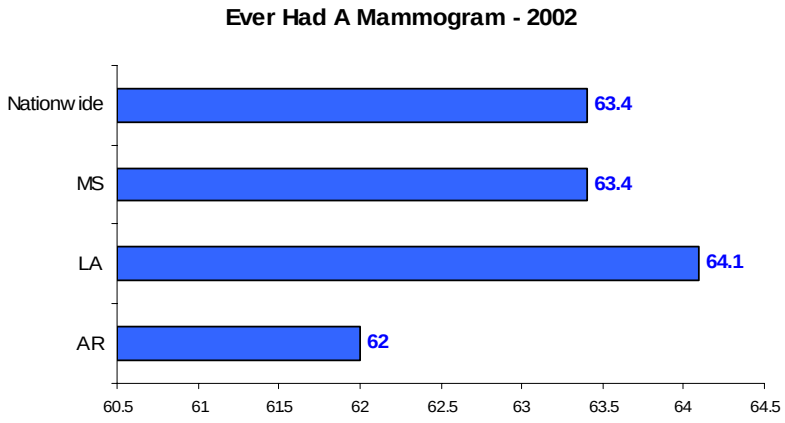


Figure 2.11 *Mammogram utilization in the Mid South, Source: BRFSS, 2003*

Mammograms are the most effective early detection screening procedure for breast cancer. Regarding utilization of mammograms, Louisiana performs slightly higher than the national average, Mississippi's is at the national average, and Arkansas's performance is substantially behind the national average.

Mississippi performs best for HIV testing, widely surpassing the other two states in the Mid South. All three states surpass the national average for HIV testing.

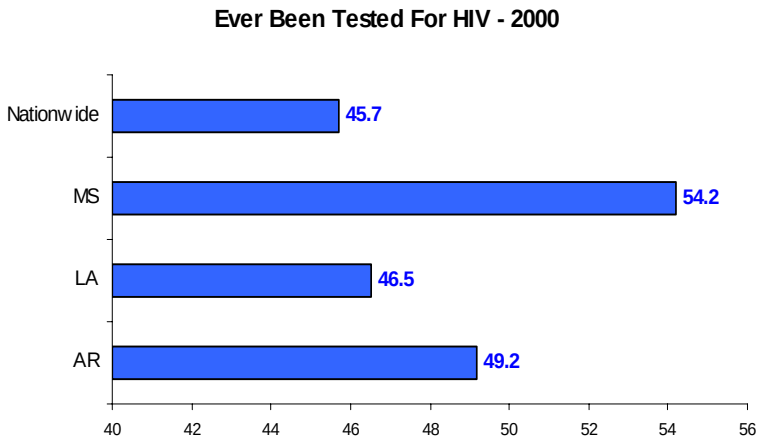


Figure 2.12 *HIV Testing in the Mid South, Source: BRFSS, 2003*

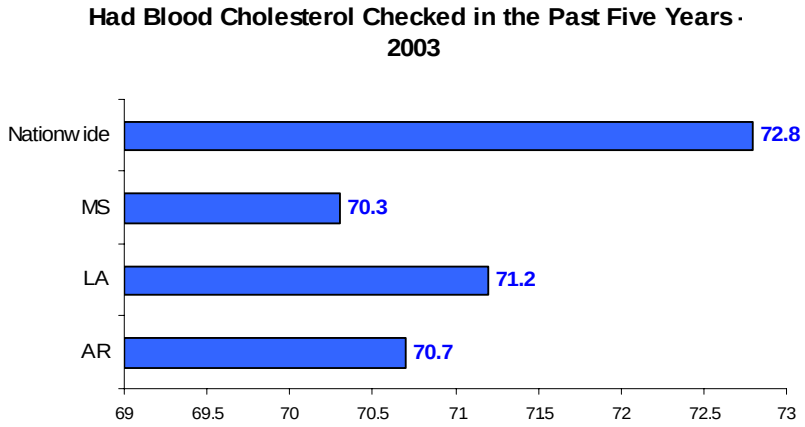


Figure 2.13. *Cholesterol Screening in the Mid South, Source: BRFSS, 2003*

Given the disease profile of the Region which includes a high levels of obesity, diabetes and cardiovascular disease, it is unfortunate that the use of cholesterol screening falls below the national average for all three states.

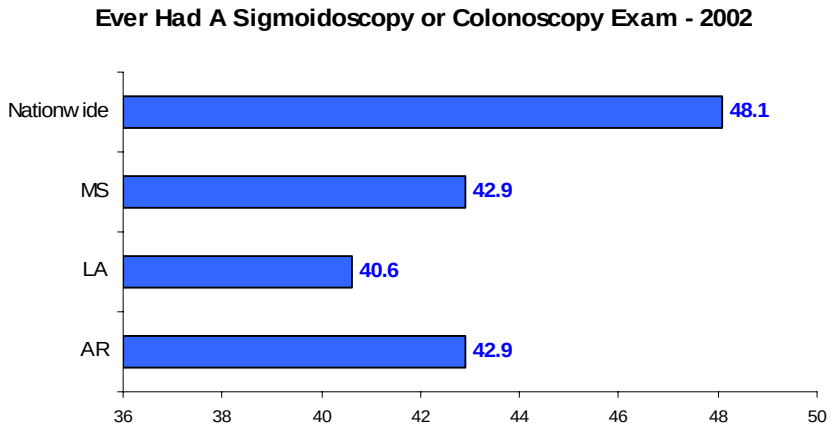


Figure 2.14 . *Colon Cancer Screening, Source: BRFSS, 2003*

The Mid South also falls substantially behind the nation in utilization of colonoscopies and sigmoidoscopies. Colonoscopies have become the standard of care for colon cancer screening in middle aged men.

Lifestyle: The Mid South lags behind the nation in healthy lifestyle choices, such as dietary habits and physical activity. Healthy eating and engaging in physical activities may be more costly, may be relatively unavailable for poor residents, and may be contrary to the social norms of individuals exposed to prolonged poverty. However, public health specialists and policy leaders are cautioned against blaming the victim for lifestyle choices. Indeed as previously explained, many lifestyle choices are related to either the social or physical environment. The goal is to propose solutions that remove the environmental barriers which contribute to unhealthy choices and create incentives that reinforce healthy behavior.

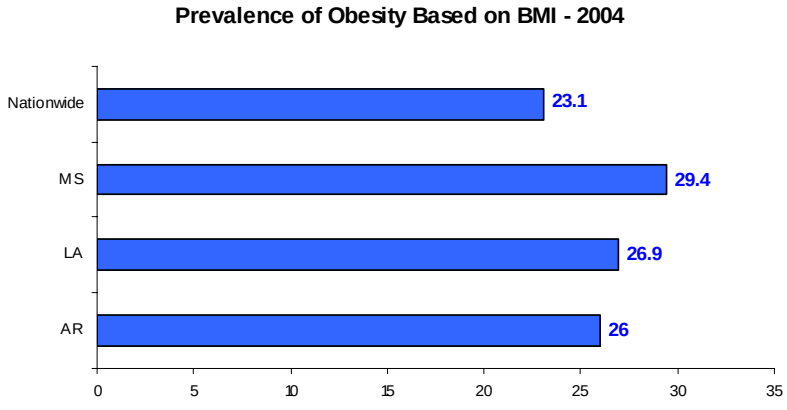


Figure 2.15 *Obesity in the Mid South, Source: BRFSS, 2003*

Obesity in the Mid South exceeds the national average, and participation in the physical activity falls substantially behind.

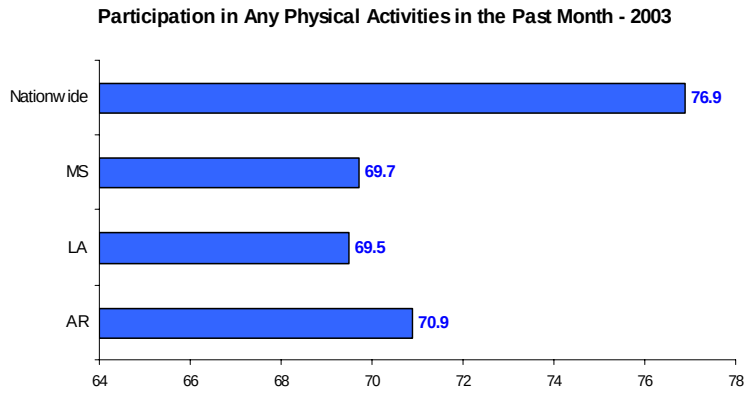


Figure 2.16 *Participation in Physical Activities in the Mid South, Source: BRFSS, 2003*

Tobacco use in the Mid South, an unhealthy behavior with many negative health consequences is also significantly higher than the national average.

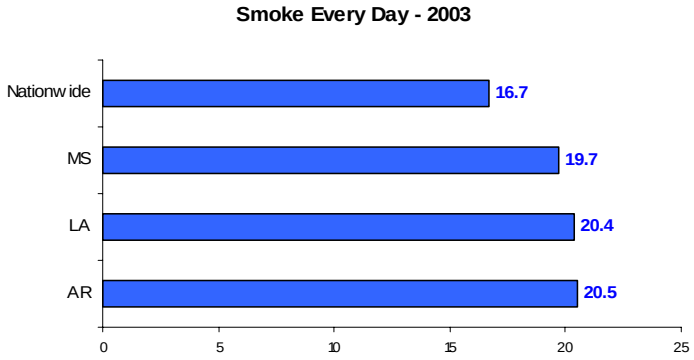


Figure 2-17. *Smoking in the Mid South, Source: BRFSS, 2003*

Conclusion: This data indicates that we have much to do to advance and improve health status in the Mid South. It also suggests that our greatest opportunities may be through focusing on prevention, and through identifying the potential opportunities to take regional approaches.

Section III

Social Determinants of Health

Section III
Social Determinants of Health

"Race, socioeconomic status (SES) and gender are social categories that are linked to either health enhancing or health-damaging factors in multiple social contexts; … and the extent to which racial, gender and SES groups are differentially exposed to common social influences and risks is striking" (Williams, 2005, pp. 115-116).

Recent analysis indicates that these dynamics play out not only at the individual level, but that marginalized communities or geographic regions reflect poor social cohesion or social capital, which exacerbate poor individual health.

Poor social and economic circumstances affect health throughout the life span, doubling the risk for serious illness and premature death (World Health Organization, 1998). It follows that the Mid South's health status substantially reflects SES status. The following map illustrates that the concentration of families living in poverty in the Mid South.

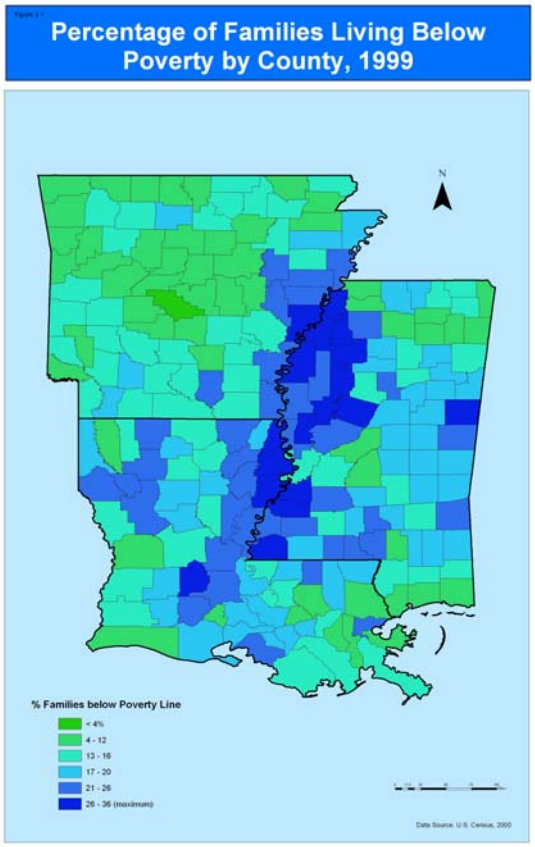


Figure 3.1. *Geographic Concentration of Poverty in the Mid South Region, Source: US Census, 2000*

Race and Gender: A high number of households headed by single females further characterizes the profile of the impoverished in the Mid South. The relationship between poverty and female headed households is illustrated below. The Institute for Women's Policy Research reports that female headed households impact upon the condition of the entire family, starting with early life and role of adequate social supports. It clearly speaks to the need to include female focused interventions to change to the poverty dynamic of the Mid South.

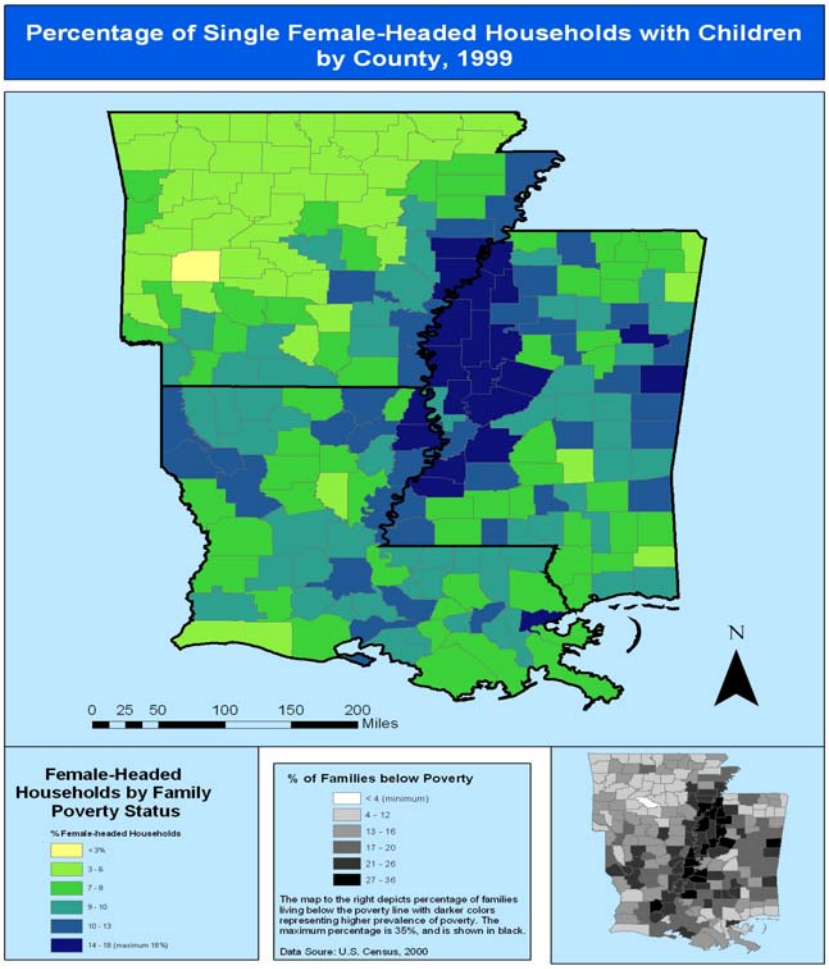


Figure 3.2. *Geographic Location of Female-headed Households in the Mid South, Compared to Locations of Families that Live Below Poverty. Source, US Census 2000*

Meaningful and Safe Employment. "Participation in meaningful work is important to psychological as well as economic well-being" (Williams, 2005, p.116). Having little control over one's work is stress inducing, and is associated with increased risk of illness, back pain, sickness-related absences, and cardiovascular disease (World Health Organization, 1998). Racial minorities and low–SES individuals have higher levels of unemployment, and job instability than their more socially advantaged peers, and are more often in lower level of management positions. Men, low-SES individuals, and disadvantaged racial/ethnic groups are more exposed to economic marginalization and separation from the work force (Williams, 2005). Male health is also adversely affected by their disproportionate exposure to occupational stress and poor working conditions.

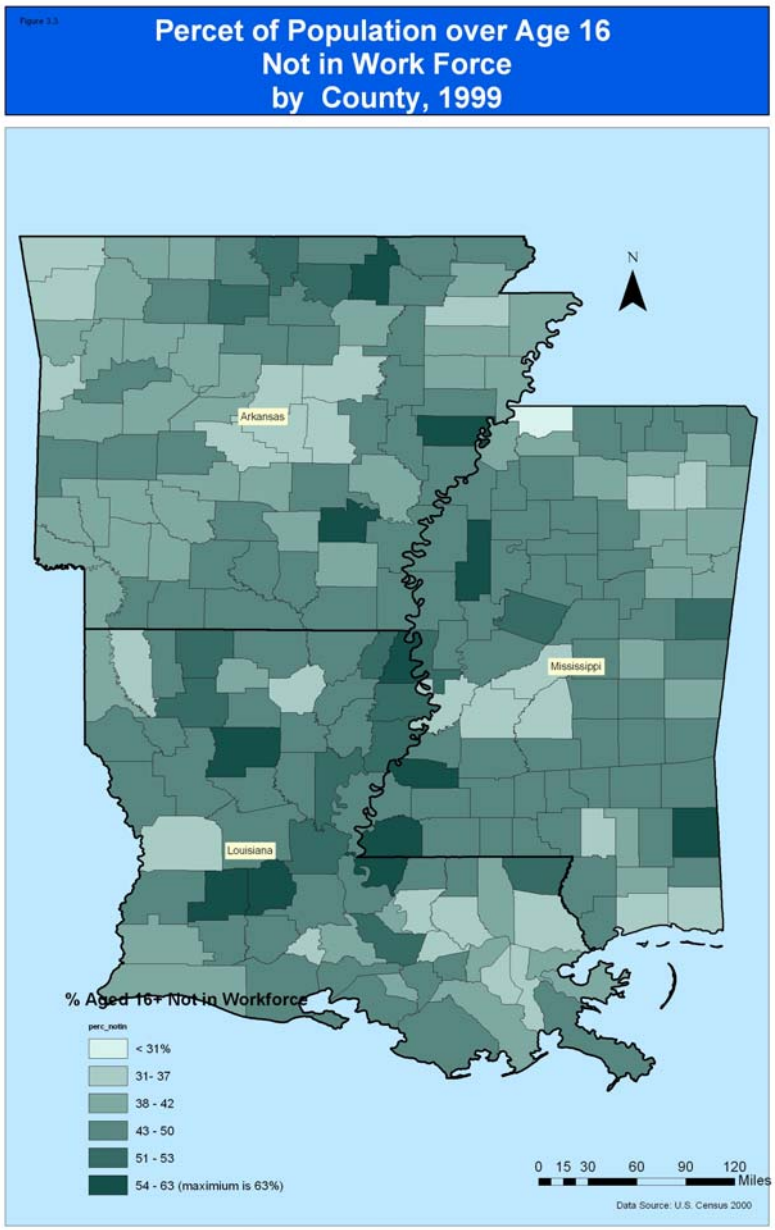


Figure 3.3 Population Over Age 16 who are not in the Workforce in the Mid South, Shown by Geographic Location, Source U.S. Census 2000

Low Educational Attainment: Figure 1.2 illustrates lower educational attainment in the Mid South compared to that of the nation. The learning gap is even more pronounced when comparing educational achievements of African American residents to that of Caucasians. The following map shows the smaller number of high school graduates that reside in the Delta Region of the Mid South, the area with the greatest concentration of African American communities.

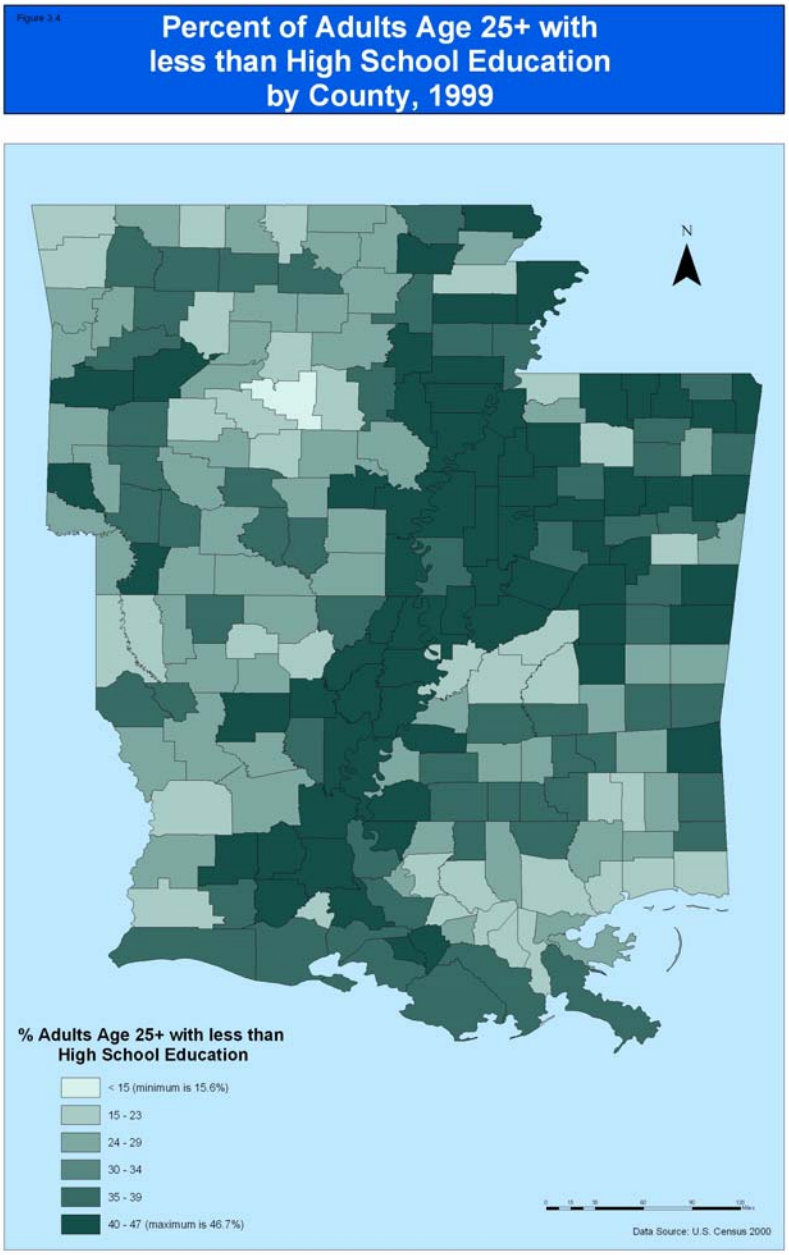


Figure 3.4. *High School Education Attainment in the Mid South Shown by Geographic Area, Source, US Census, 2000*

The Foundation of the Mid South commissioned a study in 2004 that also highlighted the racial gap between Mid South High School graduation rates. In Arkansas, there was an 11 percent gap between African American high school graduates (69 %) versus Caucasian graduates (69 %). In Louisiana, there was a 14 percent gap between African American high school graduates (62 %) and Caucasian high school graduates (76 %). In Mississippi the gap was 7 percent between African American high school graduates (61 %) and Caucasian high school graduates (68 %) (Foundation of the Mid South, 2004).

High Incarceration: Youth who do not complete high school limit their future career options and earnings potential. Many African American young adults turn to criminal activity to address their financial needs. The Foundation for the Mid South found that in Arkansas and Mississippi, there are nearly as many African American males in prison as there are in institutions of higher learning during 2000 and 1999 respectively). In Arkansas, there were 6,200 in prison in 2000 versus 6,415 in higher education during 1999. In Mississippi, there were 13,000 in prison versus 15,315 in higher education. In Louisiana, there were substantially more in prison, 25,000 versus 20,624. (Foundation for the Mid South, 2004).

Early Childhood Development: Poor social and economic circumstances present one of the greatest threats to a child's growth, and launches the child on a low social and educational trajectory (World Health Organization, 1998). Poor prenatal care, infant nutrition, and opportunities for positive early childhood development experiences affect physical and cognitive development. This pattern of poor health and limitations to educational opportunity hinders later educational achievement, access to employment and economic elevation, and leads to poor health in adult life.

Stress, Resources and Health Behaviors: Stress can be induced by social and psychological circumstances; and if sustained over long periods of time can lead to poor mental and physical health status. Stress is physiologically associated with lowering the body's immune response, making individuals more susceptible to illness and infection. Prolonged exposure to stress may cause premature aging or a weathering effect in individuals. Poor housing, few family assets, unstable employment, stress in the workplace or in the neighborhood, social isolation, and lack of social support are all social stressors.

Low SES individuals have disproportionate exposure to social stressors and fewer resources to ameliorate some of the negative effects. Some of these issues are rooted in gender differences. For example, women are more likely to seek emotionally support through friends or church relations. Men's cultural scripts urge them to avoid displaying emotion and men are less likely to seek and receive interpersonal support (Williams, 2005). Stress is also linked to alcohol and drug abuse. Higher levels of stress are associated with the initiation and continuation of substance use. Alcohol and substance use are strongly patterned with SES, with the rates being two to three times higher for the lowest compared to the highest SES category (Williams, 2005).

Section IV

Seeking Innovation

Section IV
Seeking Innovation

This section attempts to provide a framework for identifying the most effective innovations for improving health status in the Mid South. First, its takes account of the demographic and health profile of the region that has already been presented. Secondly, it considers the recommendations from the Mid South Taskforce that was convened by the Foundation for the Mid South in June 2005, which are summarized below. Third, it incorporates some of the latest research on innovative strategies that can address health disparities through focusing on understanding social determinants and the root causes of health disparities.

In June, 2005, the Taskforce was asked to prioritize approaches they believe can have the greatest impact in making health status improvements. Their recommendations reflected the following themes:

- Creating community environments that **promote health and wellness** through schools, homes, churches, and community institutions that promote spiritual, physical, and mental well-being; and that consider impact of income, environment, i.e. social determinants on health.
- Promoting **connectivity among providers** of health services, for sharing pertinent information, improving coordination and collaboration between providers, improving **continuity of care**, and promoting efficiency and effectiveness of care.
- Promoting program knowledge and innovation that is **data driven**; that respects community input; and that emphasizes community control through residents and providers.
- Increased emphasis on **program evaluation**.
- Taking a **systems approach to change** that focuses on state and local agencies; considers comprehensive community development and economic development. For example, approach health professions development as a workforce development issue.
- Improving **transportation** to provide clients with better access.
- Advocating for **more equitable distribution of resources** among provider types and for funding appropriate levels of care (more primary vs. tertiary care).
- Improving **cultural competency** of providers and developing new systems that use "common sense" policies and procedures.
- Improving **community mental health** systems.

During his tenure as US Surgeon General, Dr. David Satcher introduced an aggressive national public health agenda. One of the goals of this agenda was to "*close the gap"* in health status between racial and ethnic groups. The first step of the process was to conduct research, which was followed by funding evidenced-based practice. Several themes have emerged from available research including 1) linking the causes of health disparities with social determinants; 2) clarifying the role of root causes in disease pathways; and 3) recognizing the effects of unequal health care services due to racially-motivated discriminatory practices and unequal distribution of health resources.

The following diagram illustrates the causal pathway between SES and poor health status and the complex and deeply rooted interrelationships between race, socioeconomic status, and health status (House and Williams, 2000). The persistence of poverty and poor health among certain racial and ethnic groups in targeted geographic regions are exacerbated by the interaction of these factors.

Williams' et al (2000) model illustrates that racial/ethnic status is a major determinant of every indicator of socioeconomic position, starting with education, occupation, income, and assets or wealth. Second, the model illustrates that race/ethnicity has effects on health that are independent of socioeconomic differences between racial/ethnic groups. Third, socioeconomic position is influenced by the previous generation. The significance of the model is to illustrate the most important leverage points for improving health status. The link between racial identity and social status is the most basic leverage point to changing the health condition.

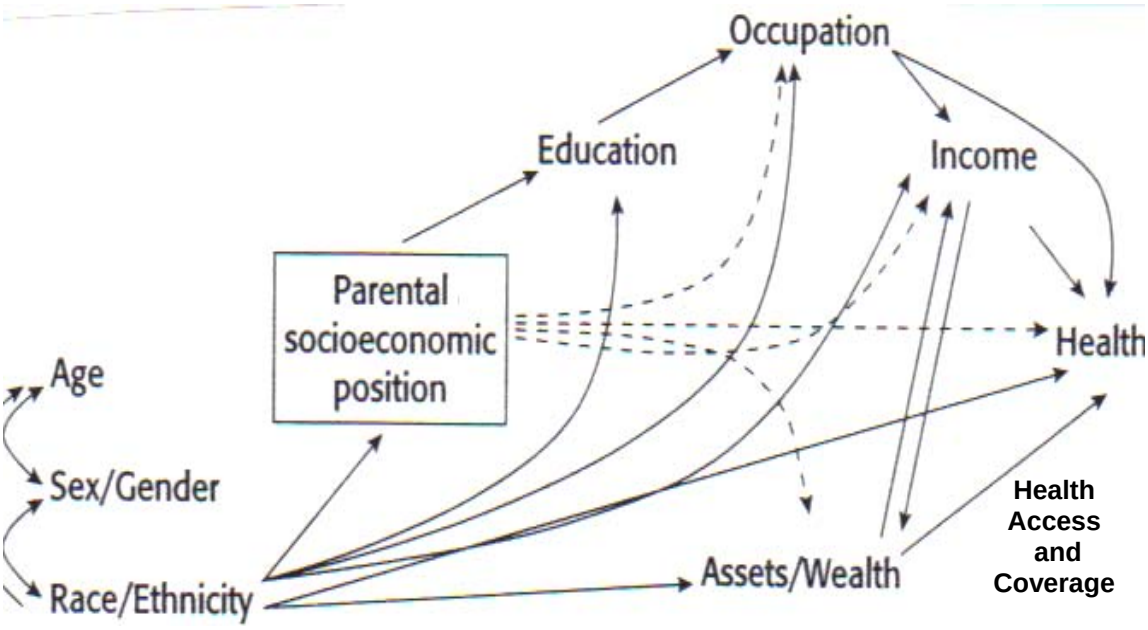


Figure 3-1. *Modified version of House-Williams Model showing SES influences social position, educational status, occupation status and income, and how they lead to health status.*

"Given that specific health risks are embedded in larger social and political contexts, effective interventions must take into account the historical and cultural factors that shape the experiences and living conditions of various social groups" (Williams, 2004, Pg. 124). The rural and inner city minority poverty that spans the Delta area of the Mid South adversely impacts economic and social opportunities within Delta communities and the entire region. It is more difficult for individuals to improve their financial status when they live in a region or community that is relatively socially isolated and that faces severe economic constraints. It has also been demonstrated that individual and community financial capacity affects education and health status. It is incumbent upon leaders to advocate and institute policies that improve educational and employment opportunities in high poverty regions.

The Foundation for the Mid South has already accepted that "race matters" and is actively working toward an agenda of racial, social, and economic equity in the Mid South. This work began with a thorough self-examination of the origin of racial inequities in the Mid South and the development of a new set of operating strategies that promote equity (Foundation of the Mid South, 2004).

Community Leadership and Coalition Development: The Foundation considers leadership development, and in particular, the empowerment of local community members as an important strategy for building more equitable communities. Williams' (2004) research also reported on a U.S. task force that identified social cohesion (civic engagement, and collective efficacy) among six factors in the social environment that are determinants of health. Minkler asserts that community organizing and community building are essential elements of achieving community health (Minkler, 1999).

Policy Initiatives that Reduce Regional Poverty: This Resource Report clearly points toward economics and education as two critical leverage points for interrupting the pathway to poverty and disease. Addressing poverty as a root cause involves improving the economic or financial welfare of the target population. Economic development initiatives in high poverty areas that ensure inclusion of targeted groups can impact health status. For example, a welfare reform initiative that provides job training and placement, as well as extending Medicaid coverage, can improve the financial stability of families. Examples that specifically fall within the realm of heath care include training and utilization of lay health workers such as outreach workers, child development associates (CDAs), certified nursing assistants (CNAs), and licensed practical nurses (LPNs). These training opportunities can lead to upward mobility when they are accompanied with articulation agreements at community colleges that encourage and enable career enhancement opportunities.

Policy Initiatives that Improve Educational and Health Equity: Early education has been demonstrated to provide greater opportunities for successful employment and breaking the cycle of poverty (Williams, 2004). A strategy that addresses social determinants and root causes is expanding early childhood education into an impoverished area. It can include training of community residents as CDAs and providing financial incentives for small child care centers to expand and to improve the quality of services.

Advocacy for more equitable distribution of resources to address needs in high-poverty school districts, states, and regions is another important educational strategy. More equitable and responsive funding of public primary education should be demanded, and innovation promoted. At the higher education level, African American professors represent a small fraction of faculty in publicly-funded predominately Caucasian institutions. Additionally, the financial conditions of publicly-funded historically African American colleges and universities are often unstable. Public policies and advocacy efforts should be targeted at eliminating these inequities. Predominantly Caucasian institutions that have benefited from generous public support should be required to develop aggressive plans to increase the presence of minority faculty; and funding for historically African American public colleges and universities should be stabilized so that their educational product can be improved (Sheheen, 2004). Higher education institutions should invest in health academies and pipeline programs that encourage and support disadvantaged and minority students' enrollment and successful matriculation. This initiative can not only improve the provision of culturally acceptable care, but can break the cycle of poverty.

Primary Prevention as a Means to Reducing Health Disparities: The California Endowment views primary prevention as an opportunity to change the environmental conditions in communities. Primary prevention can achieve both short and long-term results in reducing health disparities. The Endowment purports that focusing on root causes of health disparities such as poverty and racism may be too broad, and focusing on individual medical care or on changing individual behavior may be too narrow. An alternative approach involving primary prevention can focus less on the specific health problem such as heart disease, and more on reducing the underlying causes such as tobacco use (California, Endowment 2002). "Selecting the appropriate environmental intervention requires an analysis of the underlying factors that influence health… tobacco, diet, activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and illicit use of drugs" (California Endowment 2002, Pg. 6).

Specific populations or populations at risk due to social and economic inequality are more susceptible to disease and illnesses that may be environmentally related. People affected by disparities may live in environments where they are exposed to toxic contaminants, have inadequate access to nutritious foods, have lack of opportunities for recreation, exposure to high levels of community violence, high unemployment, and targeted marketing and availability of tobacco and alcohol products. Such environments do not support healthy behavior, promote behavior change, or provide protective factors against disease.

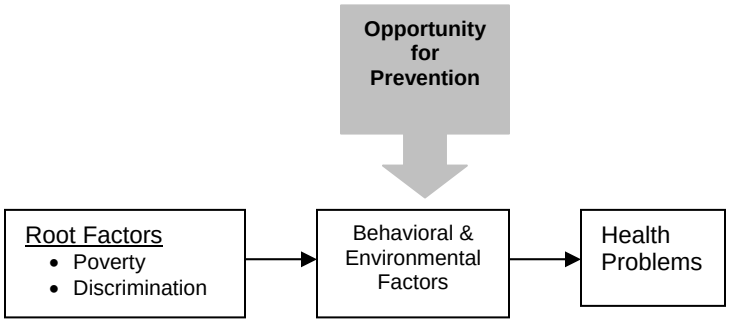


Figure 3-2. *California Endowment's Model for Primary Prevention – The most effective stage for intervention is modifying environmental and behavioral factors.*

The Endowment proposes that primary prevention strategies which address environmental conditions can assist an entire community. Smoking for example, is associated with stroke, cancer, and heart disease. Community level strategies that seek to reduce smoking are primary prevention strategies. Examples of changing the environment include increasing the cigarette tax, promoting smokeless environments in restaurants, or banning advertisement of tobacco products in urban areas along school routes or playgrounds. Changing the environment removes the responsibility from the individual to the society, and has a more profound impact.

This level of change requires unique approaches. Community level interventions that change the environmental causes of disease are often the work of coalitions. Coalitions of organizations are usually more powerful than any organization working alone. Reductions in cigarette smoking often requires the active involvement of professionals and volunteers from a broad range of organizations, including government, health professional groups, community agencies and business. Coalitions can change the practices of major institutions,

corporations, and governmental agencies. Best practices might offer effective examples for coalitions to use for tobacco cessation; removal of toxic waste sites near communities; obesity reduction through promotion of school nutrition; or coalitions including public housing to address asthma prevention.

Improving Medical Care through Eliminating Unequal Treatment: As previously mentioned, medical care is not a primary determinant of health. Of the 30-year increase of life expectancy achieved since the turn of the century, only about five years of this increase are attributed to medical care inventions (California Endowment 2002). Medical care treats one person at a time, and medical interventions often come late. The lack of race parity among medical providers also results in cultural competency problems. According to Williams, a recent study of patients in sixteen urban primary care settings found that race concordant visits reported higher levels of satisfaction and judged physicians' participatory decision-making style more positively; and race concordant visits has a more positive emotional context (Williams, 2005).

There is recent support for the idea that a more significant impact can be achieved around reducing health disparities if the intervention is focused on institutional rather than individual provider change, especially within large medical institutions. In Unequal Treatment, the Institute of Medicine (IOM) advocates for a multi-level strategy to eliminate disparities in treatment of racial and ethnic minorities. Although culminating with the clinical encounter, these disparities are of complex origin, rooted in historic and contemporary inequities, and involve many participants at several levels (Institute of Medicine, 2003).

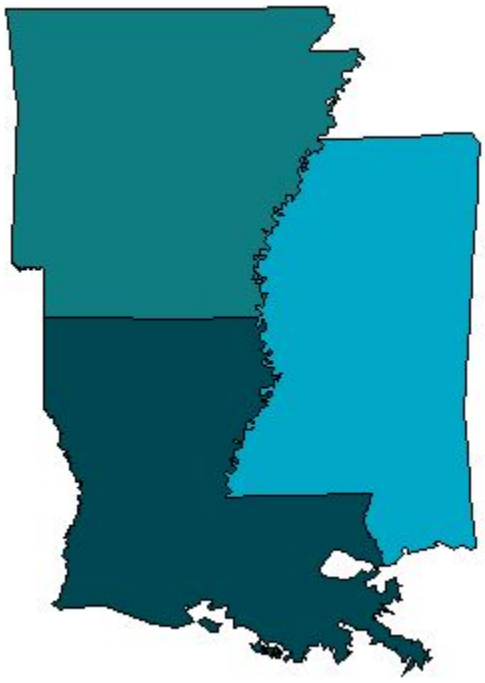
Three IOM strategies can form the basis of best practices well-suited to the Mid South initiatives: 1.) Addressing healthcare workforce issues and seek to substantially increase the proportion of underrepresented racial and ethnic minorities among health professions. 2.) The education of health providers should include cross-cultural curricula integrated early and throughout their training. 3.) The collection, reporting, and monitoring of patient care data by health plans and federal and state payors to assess progress in eliminating disparities.

Targeting the Most Vulnerable and Early Detection: Targeted outreach to the most vulnerable communities is required to close the gap in health disparities. Early detection and treatment of diseases can reduce disability, improve quality of life, and maintain family financial stability. The Healthy People 2010 initiative called for improving access to medical care for vulnerable populations through more equitable distribution of providers. There are examples of successful public health interventions that conduct culturally acceptable outreach to specific populations to increase screening and early treatment for cancer, HIV/AIDS, heart disease and diabetes. More intensive replication of successful efforts is needed to address the significant and growing gap in health outcomes.

Conclusion: Six strategies have been presented that seek to guide interventions to reduce health disparities and improve health status. These strategies represent the current thinking of competent public health and social scientists, and complement many of the programs that are already in practice in the Mid South. The idea of regional approaches was also touched upon. The opportunity may be for Foundation of the Mid South to convene a regional work group to share promising practices and work on a regional policy agenda. The next section will provide examples of promising practices.

Section V

Promising Practices



Section V
Promising Practices

Profiling successful programs in rural and underserved communities provides a blueprint for health leaders and program directors to identify projects that may be effectively replicated in other communities. This component of the Resource Report primarily profiles innovative programs from the Mid South, although a few good ideas from nearby states were also included. This section is not exhaustive as there are many more programs that deserve attention. Rather, it presents a few programs from the Mid South, and implies the need for more extensive research to identify other programs.

The taskforce participants from the first convening stressed the need for communities to review *"best practices,"* as a step to program development. Many programs in the Mid South are working on innovative approaches to improve health status, but few have adequate funding to conduct scientific evaluations. Some of programs presented are relatively new, and more evidence is needed to validate their impact on health in their target areas. Therefore the term *"promising practices"* is used rather than "*best practices."*

It is well known that not enough interventions have been subjected to strong evaluations, producing a significant gap in knowledge regarding which interventions work (Williams, 2005). This conference and the Resource Report support the idea of program evaluation. One suggestion to communities and state health programs is to partner with nearby universities to develop scientific program evaluations designs and to commission universities or qualified professionals to act as independent evaluators. Disciplined evaluation can improve evidence of effectiveness to guide future investments in the Mid South. Evidence-based interventions and applied research can ensure that further investments are made in programs that are either making an impact or at least can aptly discern if no impact is being made.

Program: ***The Witness Project***
Strategy: ***Targeted Outreach, Screening and Early Detection***
Focus: ***Breast Cancer Prevention***
Population: ***African American and Rural Women***

Charlie Stayton, Project Director
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Fax: (501) 526-7109
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Project Description: The Witness Project® of Arkansas is part of a national organization that provides education on breast and cervical cancer to African-American and rural women at 32 sites in 22 states. The program refers for or provides pap tests, pelvic exams, mammography and clinical breast exams. The national program is based on a model that originated in 1991 at the University of Arkansas for Medical Sciences to address racial disparities in breast cancer. The incidence and mortality rate for breast and cervical cancer among African Americans is twice and three times that of Caucasians, respectively. African Americans are less likely than other racial/ethnic groups to be diagnosed for breast cancer at an early, treatable stage and as a result are more likely to die from the disease. Their five-year survival rate for breast cancer is significantly lower than that for Caucasian women. Women who are poor or elderly, especially those living in rural areas, also have lower rates for cancer screenings.

Barriers to early cancer detection among African-American women include lack of information about cancer and screenings, no physician recommendation, no insurance, inability to pay, transportation problems, or fear or fatalism about cancer. Research has shown that effective health education messages fit with the literacy level and cultural characteristics of the population served. Dr. Deborah O. Erwin, a medical anthropologist, and Dr. Thea Spatz, a health educator, based the model for The Witness Project® upon their anthropological fieldwork and other qualitative research in African-American communities in Arkansas. The intervention they designed is compatible with religious beliefs and local concepts about health of the women they wanted to serve.

In 2004, The Witness Project® of Arkansas had sites in 14 counties in central and eastern Arkansas, conducting activities to increase awareness, knowledge, and screenings in breast and cervical cancer in African-American and persons of other marginalized groups, including women living in rural and medically under-served areas. A small number of

Hispanic/Latino women were also served, and efforts are underway to expand the program to fully serve this population. Three full-time staff and 80 volunteers run The Witness Project®, which has an annual budget of $250,000 and is currently funded by Avon and Breast Care of Arkansas. Past funding sources include the University of Arkansas at Little Rock, the American Cancer Society, a Title XX grant from the Arkansas Department of Health, the Susan G. Komen Breast Cancer Foundation, the National Cancer Institute, and the Centers for Disease Control and Prevention.

The Witness Project® is a culturally competent and community-based program that reaches women through presentations at churches, health fairs and other community locations. Outreach is primarily conducted by Witness Role Models (WRMs) and Lay Health Advisors (LHAs). The WRMs are African-American cervical or breast cancer survivors, whose lives are a testimony to the effectiveness of early detection. The LHAs are not cancer survivors but simply women who are dedicated to educating others about cervical and breast cancer and the importance of regular screenings. They organize and conduct educational programs, teach breast self-exam, and network in communities.

To assure that women who attended a Witness Project® educational presentation are linked to screening services, a navigators program was initiated in 2000. Women of lower socio-economic status, racial or ethnic minorities and rural areas often are intimidated by or unfamiliar with the medical system. To overcome these barriers, volunteer navigators assist with appointment scheduling, finding free or low-cost screening providers, transportation, and other services. Under-insured or uninsured women are referred to the Arkansas State BreastCare Program for free screenings.

In 2004, The Witness Project® of Arkansas services included:

- Program sites in 14 counties
- Breast and cervical awareness and education to 1,616 women
- Twelve presentations and participation in 22 health fairs
- Navigation of 549 women for breast and cervical cancer screenings
- 315 women enrolled in BreastCare for free screenings
- Of the women referred to BreastCare, 71 received abnormal breast exams or mammogram results, and one woman was diagnosed with breast cancer
- In collaboration with other health care providers, 24 Latino women, screened and received education, using an interpreter
- In collaboration with the Arkansas Department of Health, Laotian women employed at Tyson Chicken received breast and cervical healthcare screenings

- Navigation of 19 men for prostate cancer screenings.

In 2004, The Witness Project® provided 330 female participants in CycleBreakers of Pulaski County Circuit Court with education on the importance of breast self-examination and early detection for cervical and breast cancer. The program educates probationers on positive lifestyle choices to help them avoid further involvement in the court system.

The Witness Project® programs have been effective in positive behavior changes that promote breast and cervix health. Controlled studies on effectiveness showed, among Witness Project® participants:

- Significant increase in regular self breast exams
- Significant increase in mammograms
- Of women 60 years or older (a group typically with a low rate for cancer screenings), 88 percent screened.

The Witness Project® has been recognized locally and nationally for its achievements in cancer screenings for minority women. Honors include the 1991 National Honor Citation from the American Cancer Society, the 1996 Profiles in Progress Award from the Sponsors of the National Breast Cancer Awareness Month, a National Cancer Institute Partnership Award in 1996 for outstanding efforts to provide cancer information to minority populations, and recognition as one of 165 local cancer education groups across the country during the10th annual National Minority Cancer Awareness Week.

Program: ***WellnessPlus***
Strategy: ***Primary Prevention***
Focus: ***Workplace Wellness***
Population: ***Employees***

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Project Description: Employers who understand the "bottom line" understand the benefits of a healthy workforce in terms of productivity and overall benefit to the organization. As a result, many businesses are taking employee health into account and implementing programs that address the well-being of their personnel. These approaches go beyond the establishment of fitness centers and gyms and focus on empowering employees to make lifestyle changes that promote healthy living. The components of the program may vary based on the needs of the organization, but options may include health screenings, self-help programs, wellness incentive programs, interactive electronic communications, and wellness coaching with behavioral, health and nutritional experts.

The WellnessPlus program at BankPlus grew out of concern of the president for the health of his employees, especially as it related to those conditions that could be controlled or prevented by lifestyle changes. The program focuses on influencing behaviors that improve or maintain positive lifestyle choices.

WellnessPlus is designed to:

- Promote healthy lifestyles
- Encourage personal health management
- Provide comprehensive information and educational programs that properly equip BankPlus employees with the knowledge of how to realistically implement healthy habits on a daily basis

Project Activities: Each employee chooses a lifestyle that encourages health maintenance, attaining a healthy weight, or quitting tobacco use. Employees gather points as

they participate in various wellness programs and as they accomplish specific goals. WellnessPlus' point structure allows different levels of eligibility for prizes of extra vacation and cash. The integration of programs within WellnessPlus, an interactive website and a supportive corporate structure encourage high participation rates and give employees the necessary tools, guidance and knowledge to be successful in reaching their healthy lifestyle goals.

The director of Wellness and Healthy Living developed the WellnessPlus program as well as coordinates and administers the program. WellnessPlus individually teaches employees to make attainable goals realistic for their lifestyles; encourage them to go forward with a consistent effort and provide them with knowledge to be able to make realistic daily healthy choices. WellnessPlus also incorporates interactive electronic communications which allow employees, as well as the general public to access information geared toward making healthy lifestyle decisions, including daily health tips, information on various topics, employee success stories, and healthy recipes.

Target Population Served: WellnessPlus is a voluntary program available to all employees of BankPlus in all communities served by BankPlus.

Project Staffing: WellnessPlus devotes an entire department, independent from the Human Resources Department to wellness and health for every BankPlus employee.

Project Outcomes: Since the implementation of WellnessPlus in January 2003, biometric data was been submitted and tracked through BioSignia's "Know Your Number" program. After one year of programming and data analysis on 221 comparative profiles, BankPlus has seen a reduction in the number of cases of Type II diabetes, cardiovascular disease and stroke, as well as a reduction in modifiable risks for these respective chronic diseases. While correlating modifiable risk and performance levels, BankPlus has found that employees with greater than 80 percent modifiable risk for Type II diabetes, cardiovascular disease and stroke were less productive than the employees with less than 80% modifiable risk.

As expected with a prevention-focused health promotion program, doctor visits, pharmaceutical use, and allied health visits have increased, while hospital costs have decreased, reflecting an overall decrease in insurance claims. Those who participated in the WellnessPlus programming and met their lifestyle goals tend to be higher performers than those who do not participate and do not meet their lifestyle goals (Fish, 2005).

Program: ***The School-Based Dental Program, The Health Enrichment Network***
Strategy: ***Primary Prevention, Public Policy Changes***
Focus: ***Dental Health***
Population: ***School-Based Children***

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Project Description: This project was planned and implemented by The Health Enrichment Network (THEN), a formally organized nonprofit network established five years ago. The network's original mission was to offer prevention-oriented services to seniors but it has since expanded to include services to all citizens. THEN has a staff of five and a 14-member board, and provides a range of preventive services to residents including an aquatic center, wellness program, and cardiac rehab.

Because of the significant unmet dental care needs both within the parish and in the surrounding service area, the intent of this project has been to develop and implement an integrated dental care initiative to improve the oral health of Allen Parish. The dental initiative consists of three major components: 1) dental education for children; 2) dental sealants for eligible second and sixth grade students, and 3) a water fluoridation program.

The project staff created a dental coalition and conducted a needs assessment involving service area dental providers. They also leveraged several funding opportunities and in-kind resources from Crest, Oral Health America, Healthy People 2010, Office of Public Health, a dedicated local dentist, and numerous others in successfully implementing all three components of the initiative. The significant success level of this project has led to its expansion into a five-parish initiative which will occur during Phase II of this project.

Project Activities: Coalition Development. A general health coalition was already in existence in Allen Parish at the time the project began. The focus of this project was therefore to establish a dental coalition and work toward implementing a dental initiative. The coalition consists of 12 members from among the following organizations and individuals:

- The Health Enrichment Network (THEN)
- Allen Parish School Based Health Center
- Allen Parish Head Start
- Two privately employed dentists
- Karen Oertling, State Oral Health Director
- Sheri Sisson, State Fluoridation Officer

The dental team was assembled, including all school nurses in the parish and the superintendent of education, enabling the sealant project to reach every eligible child in the public schools. The water fluoridation team also involves a police jury member, parish mayors, and other community representatives. Coalition development has thus involved a broad cross-section of key individuals and organizations that are in a position to help the dental initiative go forward.

Needs Assessment: A dental care needs assessment was conducted by the project staff and coalition members, utilizing the following:

- Forums with dental providers
- Survey of 70 dentists in the three-parish service area
- Examination of pertinent dental health and dental care statistics
- Considering what the community wants in regard to dental health care
- Looking at what other states have done to bring dental care to rural areas

Of the 70 dentists surveyed in the three parish service area, only 7 or 10 percent accept Medicaid. Of those who accept Medicaid, some only accept certain age groups or certain types of dental problems. Only one dentist in Allen Parish takes Medicaid. It was also found that there is a 4-6 month wait for an appointment for dental services for Medicaid patients. During the forums, dentists related that reimbursement is low, the no-show rate is high, and although they are interested in the dental initiative, they have been "burned" and prefer not to participate. This information was shared with coalition members, who used it to develop a strategic plan and to implement the dental initiative in the parish.

Development of Strategic Plan and Service Implementation: The coalition initially considered providing restorative work, but felt this was unaffordable. They then

evaluated a prevention initiative, which they decided would provide the "most bang for the buck." The coalition looked for national models and found assistance and support from a program in Washington State. This led to their decision to implement the following three prevention strategies:

Childhood Dental Education: This strategy involved early childhood education in dental health utilizing the "building a habit out of brushing" approach. This approach is based upon the premise that it takes 30 days to develop a habit. All kindergarten children in the parish received a toothbrush kit donated by the Crest Corporation that included toothbrush, floss, a calendar, and stickers. Students were shown a video and instructed in the ways oral health affects overall health. There were 726 children who received dental health education through this initiative from all socioeconomic levels in the parish.

Fluoridation: Since no fluoridation existed in Allen Parish, a fluoridation program was piloted in Oakdale with $36,000 in funding obtained from the Office of Public Health and $2,400 from the City of Oakdale for fluoridation materials and supplies. State dollars are available for water systems serving at least 8,000, and plans are thus underway to look for other parish water systems that qualify and/or seek grants that serve smaller water systems. The coalition is also exploring the possibility of using fluoride tablets to fill in the gap until another option becomes available. The pilot fluoridation project is presently benefiting 7,200 residents in the Oakdale area.

Dental Sealants: The sealants were provided through the partnership with the Office of Public Health's Program's Oral Health American and Healthy People 2010. A local private dentist, provided in-kind screening services, while the Office of Public Health loaned an available dental chair and contracted with a dental hygienist to apply the sealants. Care was taken to meet all applicable state regulations and licensure requirements. In order not to interfere with the private patients of local dentists, sealants were targeted for use only with the school children eligible for LaChip insurance, Medicaid, or free or reduced lunch (based on self-qualification by parents). Informational materials and consent forms were distributed to parents of 503 eligible children. A total of 231 children (46 %) were screened and 192 received at least one sealant for a total of 770 sealants applied. These sealants would ordinarily cost $113 per child.

Target Population Served: Description of Geographic Area: Allen Parish is a rural parish located in west-southwest Louisiana. It has a population of 25,440 and an average population density of 33 persons per square mile. There are five towns and villages in the

parish. Oberlin, the parish seat, is located in the center of the parish with a population of just over 1,800. The largest town is Oakdale situated in the northeast corner of the parish, with a population of 6,800. The racial ethnic makeup of this parish is 72 percent Caucasian, 25 percent African American, almost 2 percent Native American, and 1 percent Asian or other. Hispanic or Latino residents of any race comprise 4.5 percent of the population. The median household income in the parish is $27,777 (per capita $13,101), and 19.9 percent of the residents live below the 100 percent poverty line. This parish is both medically and dentally underserved, with only one dentist in the entire parish who accepts Medicaid patients.

Number of People Served or Impacted by the Project:

(1) 9,700 residents were served by Oakdale pilot fluoridation project

(2) 770 second and sixth graders were screened and provided sealants

(3) 510 kindergarten-age children received dental education and a Crest toothbrush kit

Sources of Funding: The program is a subgrantee of the Better Health for the Delta initiative in Louisiana. THEN received an annual grant for $17,000, which is funded through the National Office of Rural Health Policy, Health Resources and Services Administration. The Louisiana Office of Public Health, Department of Health and Hospitals provides the dental sealants valued at $36,000. The City of Oakdale contributed $2,400 for the water fluoridation program. The grantee for the Better Health for the Delta program is the South East Louisiana Area Health Education Center in Hammond.

Program: ***Maternal Infant Health Outreach Worker Program (MIHOW)***
Strategy: ***Primary Prevention***
Focus: ***Infant Health Improvement***
Population: ***Young Mothers***

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Project Description: MIHOW is an award-winning mother-to-mother mentoring program which started in 1982. Women living in impoverished communities who are trusted locally for their energy, integrity, compassion, and commitment to their community, visit pregnant women and families with young children up to three years of age in their home to promote healthy pregnancies, healthy children, and healthy emotional bonds between children and their parents.

The program's goal is to improve birth outcomes and early child development by strengthening community resources in very low-income areas. Through monthly home visits and parenting groups during pregnancy and the first three years of the child's life, MIHOW's trained lay workers listen attentively to parents' concerns, support parents in promoting the child's physical, cognitive, and social development, model effective parenting, promote healthy living, and provide connections to community services.

By providing maternal health and empowerment resources for low-income communities, MIHOW works to restore the value of the art of mothering through educational support that nurtures a child's health and well-being and builds on the inherent strengths of every individual and family.

Target population served: Pregnant women and families with young children (birth to 3 years) who are economically disadvantaged and/or isolated. MIHOW is in rural and urban communities in 5 states in Appalachia and the deep South: Kentucky, Louisiana, Mississippi, Tennessee, and West Virginia. MIHOW has served more than 12,000 families throughout the Southeast since it started in 1982; 600 hundred families are currently being served by the program. MIHOW outreach workers made about 5,000 home visits and held 200 parenting groups in 2004. The same is estimated for 2005.

Evaluation Results: In a qualitative study, MIHOW participants reported that their sense of purpose and hope for the future had improved as a result of their involvement with the program. They also said MIHOW helped lessen their sense of isolation and increase their assertiveness with welfare and legal systems (Clinton, 1990). In another study, MIHOW mothers were found to be more consistent about good nutrition habits during pregnancy (more vitamin and iron consumption, less tobacco and caffeine consumption) than mothers in a comparison group. They were more likely to breastfeed (33.3 % compared to 22.5 %). MIHOW children scored significantly higher than a control group on the Caldwell HOME Inventory at ages 1 and 2, correlating with later IQ scores and school performance (Clinton 1992).

Project budget: The project has an annual budget of approximately $450,000

Sources of funding: Sources of funding include foundations, individual donors, Vanderbilt University, businesses.

Program: ***Minority Student Recruitment at Duke***
Strategy: ***Increasing Minority Medical Professionals***
Focus: ***Organizational Policy Change***
Population: ***Students and Higher Educational Institutions***

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National leaders in health care have declared that the lack of minorities in the health care workforce is contributing to racial and ethnic health care disparities. Both the Association of American Medical Colleges and the National Institute of Health have identified greater representation of minorities in the ranks of physicians, nurses, dentists, pharmacists, and other health care providers as critically important, if any reduction in health disparities is to occur.

The positions of the AAMC and NIH were underscored by a report issued in 2003 by the Sullivan Commission on Diversity in the Healthcare Workforce, *Missing Persons: Minorities in the Health Professions.* It warned that by the year 2050, when it is predicted that no racial or ethnic group will make up a majority of the U.S. population, that there will be a worsening crisis in health disparities if the current lack of diversity is not remedied. Institutions of higher learning were urged to adopt practices that would increase minority applicants' access to their programs. The Commission advised that significant improvement likely would not occur without institutional leaders' making a strong commitment to diversity. As a key strategy, the Commission recommended that schools and colleges of medicine revise admission practices, which traditionally emphasize GPA and standardized test scores, to give more weight to humanistic qualities in determining applicants' suitability to the medical profession.

Duke University School of Medicine is exemplary of what can be achieved in diversity efforts when there is a serious, top-down commitment. Well into the 1990s, few under-represented minority (URM) applicants were recruited; Duke had a reputation as a place that was inhospitable to African Americans. Ten years ago, Duke University president, Nan Keohane, embraced student diversity as the university's number one priority. Her successor, Richard H. Brodhead, and Brenda Armstrong, Dean of the School of Medicine,

have been equally committed to this mission. The Duke School of Medicine admissions process since then has undergone a transformation that began by asking some fundamental questions:

- Who will be the health care providers of tomorrow that we are training today?
- To whom are we accountable? How do the needs of that community relate to recruitment, admission, and education of those providers?
- What skill sets must we teach to ensure that student acquire scientific mastery, cultural competence, and a desire to serve the community? Are those attributes overlapping or are they mutually exclusive?

As the new vision took hold, medical school faculty and administrators began to advocate for changes in the university's mission, policies and practices to align them with the urgent need to address disparities in health and health care. Self-study led to the conclusion that the existing admissions practices and admissions criteria conflicted with the new conception of the school's mission. Specific concerns were the composition of the admissions committee (largely Caucasian male) and an admissions process that over-emphasized applicants' test scores and GPA to the exclusion of humanistic qualities. A retooling of admissions policies and practices resulted in:

- Broadening of Admissions Committee membership to include women, minority faculty, alumni, laypersons, and students
- Required annual training for Admissions Committee members in standardized screening and interview protocols
- New admissions criteria, standardized in a template to direct the applicant review process.

With the new admissions standards, a stellar transcript is not all that counts. More importance is now given to interviews, essays, and letters of recommendation as ways to assess leadership qualities, communication skills, breadth of human exposure, and attributes such as compassion, humility, and tolerance. Test scores and GPA are evaluated in a new light. Consideration is given to difficulty of undergraduate coursework as well as "distance traveled" by the student in his or her life course and academic career. How an individual has been shaped by economic disadvantage or privilege, parents' educational attainment, and minority status are taken into account.

In addition to Duke's new admission practices, other changes have been instituted to support the university's mission to improve diversity. The School of Medicine curriculum now includes learning and assessment in cultural competency in all four years of the program. Student-led initiatives take students into the community, which give them experiences that increase their awareness of social factors that affect health status and health care access and quality. Partnerships and pipeline programs with North Carolina school systems have been expanded and strengthened to increase the pool of qualified URM candidates. New accountability measures and incentives promote URM faculty recruitment, retention and promotion. The Duke University Endowment Fund, as well as the Kellogg Foundation, Howard Hughes Medical Institute, and Robert Wood Johnson Foundation, support this broad diversity initiative.

As a result, an institution that until a few years ago remained largely Caucasian and was regarded as inhospitable to African Americans is now lauded for remarkable gains in minority recruitment. In 2002, Duke earned top ranking from *The Journal of Blacks in Higher Education* for its integration efforts. The journal closely monitors diversity at top colleges and universities because they are the standard-setters for other institutions nationwide. In the journal's comparison of what it considered the 26 most prestigious U.S. universities, Duke earned the highest cumulative score on 13 measures of diversity. The four institutions holding top spots with Duke that year were Emory University, Princeton University, Washington University and Vanderbilt University.

Duke's efforts to attract qualified URM applicants translate into some impressive statistics:

- Doubled applicant pool for URMs
- Ninety-eight percent retention/graduation rates among URMs
- Twenty percent of Duke medical students are URMs
- Ninety-five percent of URM medical students graduate in four years or less
- Two minority faculty and one woman appointed to department chair

In addition, since Duke's new admission policies were put in place, average MCAT score and GPA for students entering Duke School of Medicine have increased. The Duke experience demonstrates the potential of institutional change to impact minority health. By the example of Duke and other institutions that value diversity, other schools of medicine

may be encouraged to embrace practices that will alter the face of the health care workforce – and ultimately improve health care and health status for racial and ethnic minorities.

Program: ***Southern Louisiana University Nursing and CNA Expansion Program***
Strategy: ***Workforce Development***
Focus: ***Expansion of Community Nursing Pool***
Population: ***Nursing Students***

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The lead agency for this project is the School of Nursing at Southeastern Louisiana University (SLU) located in Hammond, LA. This project addresses the issue of health care professional shortages in the two parish area, seeking answers and solutions to the following issues:

- Are there health care professional shortages in the two parishes, and if so, what are they?
- What are the factors that are contributing to these shortages?
- What are the most optimal ways to impact the identified shortages?

The project director and community encourager established a health care coalition that includes a range of health care facilities as well as local institutions of higher education. The coalition utilized a logic model to develop implementation strategies. A pilot program to help nursing students meet specialty care experience requirements prior to graduation was implemented during the summer of 2005. A second pilot program will allow third-year nursing students, through summer courses and the state board exam, to obtain certification as LPN's. This will increase a student's capacity for gainful employment in the senior year, while gaining specialty experience in the process. Finally, focus groups are being conducted in the two parishes to address the CNA shortage, its underlying causes, and possible solutions. The goal is to develop strategies to solve specialty care nursing shortages and CAN shortages that can serve as a model for other regions in the state.

Long Term Project Goals:

I. Develop a coalition consisting of "diverse group to address the issues" of nursing and CNA shortages in the two parishes.

II. Conduct a needs assessment to determine whether there is a nursing shortage in the two parishes and what the underlying reason is for the shortage.

III. Develop a strategic plan separately and jointly with each parish coalition to determine implementation strategies for meeting the identified health care professional shortage needs.

IV. Begin implementation of services that address the identified needs in nursing and CNA workforce development in the two parishes.

Project Activities:

Coalition Development. Two coalitions were developed, one for each parish, with the goal of developing a "diverse group to address the issues" of nursing and CNA shortages. Coalition development has consisted of meeting as a group in each parish, discussing how to progress toward the goal of the project, and to pull in as many agencies as possible in each parish. The partners in each parish agreed to sign Memoranda of Agreement (MOA) by the end of the first year. Nine coalition partners signed.

Needs Assessment. The two coalitions jointly obtained secondary data regarding the potential health provider shortages. Surveys were then distributed to key stakeholders in the two parishes on the topic of health care provider shortages, particularly nurses. These were followed up with focus groups as well as feedback from stakeholders on other potential shortages, such as phlebotomists and pharmacists.

Findings indicated that there is no numerical shortage of nurses in either parish. However, a shortage of nurses exists in specialty care areas such as critical care. The underlying reason for this shortage appeared to be the requirement for one year of prior work experience before becoming eligible to work in a specialty care area.

There findings indicated a severe shortage of CNA's in both parishes, as well as turnover, which affects the nursing homes and acute care facilities in particular. This aspect of the needs assessment was extended with more focus groups in which the underlying reasons for the CNA shortage were examined in more detail. Four major reasons were identified: 1) low salaries, 2) no child care available for CNA workers, 3) lack of

transportation to work, and 4) decrease in the number of area high school vocational programs that train CNA's.

Although the local technical colleges have some money available to pay for tuition, students often sign up but fail to attend training, or enter the workforce only to leave it shortly thereafter. It was found that students from the high school CNA programs tend to stay in the work force longer than the technical college students.

Development of a Strategic Plan. Initially each parish coalition met individually to discuss strategies for meeting the identified health care professional shortage needs. The coalitions then met jointly as implementation strategies were developed. Three different service components were developed as the implementation strategy for this project. These are described in the following sections.

- *Critical Care Shortage:* The North Oaks Medical Center in Tangipahoa and SLU will begin a pilot preceptor program during the summer of 2005. Two nursing students will participate in surgery, post-anesthesia, OR, and ambulatory one-day stay rotations, while taking two elective peri-operative courses offered by SLU that combine theory and clinical experience. The students will continue to work in these programs as nurse techs during their senior nursing year, thus becoming eligible for certification in peri-operative care (and/or ICU) by the time they graduate. This replaces opportunities for work experience during training that had been lost in the shift from a medical to an integrated nursing model.
- *Getting Nursing Students into Service Earlier via LPN Certification:* This strategy involves an innovative re-positioning in which SLU nursing students are able to take courses in OB, pediatrics, and practical nursing (roles and responsibilities) from one of the two technical colleges during the summer after the junior year, and then sit for the LPN state boards in July. This will enable these students to be hired as LPN's during their senior nursing year, thus giving them more income as well as helping them meet the first year of work experience required for special care areas. Louisiana Technical College in Hammond will attempt to get nurses back into the field by offering a nurse refresher course.

- Addressing the CNA Shortage: This has been the most difficult shortage to address since the barriers of transportation, child care and low salaries remain. Three potential strategies to address this issue are in a formative stage, as follows: 1) development of a "Patient Care Technician Program" by the two technical colleges enabling students to take the first 130 hours to become CNA's complete the next higher set of hours for Phlebotomy certification, and complete the next higher set of hours for EKG technician certification. This is a form of articulation and makes students eligible for Pell grant funding. A pilot class of CNA's is scheduled for fall of 2005; 2) continuing the high school CNA program can avoid some barriers such as lack of transportation or child care. Tangipahoa still has the program while Washington has dropped it; 3) still in an early stage, a third strategy may be to pull together agencies in the two parishes that hire CNA's to discuss existing and possible new incentives for drawing more people into the field as well as reducing turnover.

Service Implementation. Pilot projects have been implemented starting in May 2005 and extending into the summer and fall. Data from the pilot projects will be utilized to make adjustments and then fully implement the programs.

Target Population Served: Nursing Students attending a local University that provides the two parish area with nurses, CNA's and LPN's.

Description of Geographic Area: The project is a two-parish initiative involving Tangipahoa and Washington Parishes in southeast Louisiana north of Lake Pontchartrain. Tangipahoa Parish has a population of over 100,000 people, with a population density of 127 persons per square mile. There are eight incorporated communities in the parish. Amite is the parish seat while Hammond is the largest town with a population of over 15,800. The per capita income for the parish is $14,461, with almost 23% of the population below the 100% poverty line. Tangipahoa Parish is relatively rural but closer to larger metropolitan areas than Washington Parish. The southern portion of the parish is in transition as north shore suburban areas of greater New Orleans expands into the parish.

Washington Parish, located adjacent to Tangipahoa, is a very rural area with high poverty and a relatively low level of educational attainment, factors that have had an adverse impact on health care and health care practitioners. The parish is bordered on the north and

east by the State of Mississippi. It has a population of almost 44,000 and the average density is 66 persons per square mile. There are four incorporated communities; Franklinton is the parish seat while Bogalusa is the largest town with a population of 13,400. The per capita income is $12,915 and 24.7% of the population lives at 100% poverty.

Operational Period and Dates of the Project: The program started in September of 2004, and is ongoing.

Project Results or Outcomes: This project has demonstrated an exemplary level of accomplishment during the past two years in the development of coalition partners, identification of nursing and CNA shortages and needs, and development of strategies and pilot programs to meet workforce needs in the specialty care nursing area.

Sources of Funding: The program has an annual budget of $17,000, and is funded by the National Office of Rural Health Policy through the Better Health for Delta Program, Department of Health and Human Services, Health Resources and Services Administration

Program: ***The Partnership for a Healthy Mississippi***
Strategy: ***Primary Prevention, Public Education***
Focus: ***Tobacco***
Population: ***General Population***

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Project Description: Tobacco-related illnesses are the most preventable health consequences facing our state. Nearly 5,000 Mississippians lose their lives every year due to tobacco use. The economic toll to treat tobacco-related illnesses in Mississippi each year tops $600 million. The impact of tobacco use is even more disconcerting when considering that nearly 82,000 children alive today in Mississippi will die early from a tobacco-related disease.

Given that most use of tobacco products is initiated before the age of 16, and the tactics used by the tobacco industry to lure children into using their products, the focus of channeling resources on the adolescent population appears to be the most effective strategy for mediating tobacco use. The literature strongly suggests that youth who do not begin use during adolescence or the early adult years will lead a tobacco-free life (Institute of Medicine 1994.) Consequently, comprehensive interventions, particularly school education programs that involve and educate both school and community are suggested to prevent beginning use of tobacco (Glynn 1993; Peck and Acott 1993).

Following Mississippi's settlement of its suit against the tobacco companies, a two-year pilot program was developed to provide a comprehensive approach to combating youth tobacco use. The program was designed to incorporate advocacy, education, public awareness, law enforcement, research and evaluation and was implemented by what has since become known as The Partnership for a Healthy Mississippi, also known as "The

Partnership." The Partnership builds upon preexisting resources within eligible communities and utilizes an alliance of public and private organizations, youth, civic, charitable and faith-based organizations to implement effective tobacco prevention and cessation programs. These local partners have an established history in their respective communities; their tobacco prevention and control efforts add another dimension to their community service. Local programming is developed within the general guidelines established by The Partnership, but grants are flexible enough to allow customization to fit the specific needs of each community. The Partnership provides grants, education, expertise and technical assistance to each of its community partners.

Long Term Goals: The mission of The Partnership is to improve the culture of health in Mississippi. The Partnership's website maintains that it "...combines community and faith-based efforts with school programs, a school nurse program, cessation support, counter-marketing and the enforcement of laws that prohibit the sale of tobacco to minors." The Partnership will continue to reduce tobacco initiation by youth, lower adult usage rates and engage in policy efforts that protect Mississippi's citizens from the dangers of exposure to secondhand smoke.

Project Activities: The Partnership's programs are based on archetype research, the Precede/Proceed model for changing behavior, as well as guidelines from CDC's best practices for tobacco control and prevention. Programs include:

- Tobacco prevention for all ages
- Teacher education and training materials for teachers
- School tobacco nurses in 52 school districts
- Faith-based prevention programs
- After-school and mentoring activities
- Counter-marketing to support program messages
- Law enforcement training and compliance programs
- On-campus tobacco prevention and cessation at all four-year and community colleges
- Statewide Tobacco Quitline (800-244-9100)
- 33 community youth partnerships implementing programs in all 82 counties
- 13 regional sites that offer tobacco cessation classes in conjunction with the University Medical Center School of Dentistry

Target Population Served: Tobacco education is provided to students from kindergarten through college. The education component incorporates information about the health dangers of tobacco use as well as skill-building activities to improve communication skills and build self-esteem to decrease their risk of involvement in other health-threatening behaviors. Cessation programs and tobacco treatment services are available to anyone who needs assistance overcoming a tobacco addiction.

Number of People Served or Impacted by the Project: The Partnership is a statewide effort and provides some form of prevention activities in all 82 counties. The school nurse program is present is 52 communities. Local community/youth partnerships unite all segments within communities to implement awareness activities and prevention programs at the local level. The Tobacco Quitline, a toll-free cessation counseling program, and the ACT Tobacco Treatment Program, which operates 13 clinics across the state, are available for anyone interested in tobacco cessation. All of The Partnership's programs are offered free of charge to the public in Mississippi.

Sources of Funding: The Partnership is funded through a portion of the State's tobacco settlement.

Project Results or Outcomes: Mississippi has been fiscally responsible in its tobacco control efforts. The Campaign for Tobacco Free Kids which monitors states' tobacco prevention/control efforts, reported that for fiscal year 2006, Mississippi is one of only four states funding tobacco prevention programs at minimum levels as recommended by the Centers for Disease Control. For the past consecutive seven years, Maine and Mississippi are the only states that have funded programs at the proposed level.

Evaluations from the Social Science Research Center (Youth Tobacco Survey), conducted in conjunction with CDC and the Mississippi Department of Health, show that from 1999 through 2004, smoking has decreased 32 percent among public high school

students and 48 percent among public middle school students. The Partnership's success is estimated to have already saved the state more than $500 million in future healthcare costs.

Program: The Louisiana Revolving Loan Fund
Strategy: Economic Development
Focus: Health Infrastructure Capacity Development
Population: Public and Private Health Providers

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Project Description: In Louisiana, the Robert Wood Johnson Foundation (RWJF) grants, through the Louisiana Rural Health Access Program (LRHAP) funding for the revolving loan fund. The South East Louisiana Area Health Education Center (SELAHEC) was contracted by LRHAP to develop the Louisiana Rural Loan Fund in 2000.

The revolving loan fund program was established so that rural doctors, clinics, hospitals and other providers could make long-term investments to improve the facilities where they provide patient care. The revolving loan fund provides access to capital that can be used to buy, build, renovate or expand facilities; purchase medical equipment or computer systems; refinance current debt at a better interest rate; or be used as working capital until a practice can become self-sustaining.

Louisiana's Long Term Goals:

1. Provide direct and subordinated loans to help improve access to primary care in rural Louisiana communities and improve healthcare facilities
2. Become a self certified CDFI or Community Development Financial Institution

Project Activities: The availability of seed capital makes it easier for providers to acquire bankable loans. The seed capital often serves as equity to allow layering of multiple financing sources making higher risk loan applicants more attractive to traditional lenders. While small community banks are the cornerstone of this loan fund's success, relationships have been developed with larger banks to fund larger projects. For example, a $200,000 investment by the loan fund, a $5 million capital outlay during former Governor Mike Foster's term, a $5 million USDA direct loan and a $5 million loan from a commercial bank with a USDA guarantee provided the necessary funding for the replacement construction of a small rural hospital in St. Mary Parish. This hospital had pending designation as a critical access hospital.

Most loans are for smaller amounts and some do not require any amount from the program's capital pool. Human capital in the form of technical assistance and support make the difference between a loan moving forward and remaining a wistful thought. Two examples of successful loans have been made to KidKare Multipractice Clinic in Washington Parish for program expansions, and to the St. Helena Healthcare Clinic for a replacement facility.

Target Population Served: Physicians, hospitals, community health centers, rural health clinics, rehabilitation and other facilities and other healthcare providers through out the three states. As of January 2005, the Louisiana revolving loan fund program has facilitated or made 25 loans through direct lending, collaborative lending, or through providing only technical support.

Description of Geographic Area: Each of the loan fund program serves their entire state.

Operational Period and Dates of the Project: The program began in December of 1998 and is ongoing.

Sources of Funding: The RWJF granted, through the LRHAP, funds to plan and develop the revolving loan fund program and to identify sources of initial capital for the fund pool. LRHAP contracted with SELAHEC to develop the program, provide technical assistance to healthcare providers, and to support marketing activities. The Louisiana Public Facilities Authority (LPFA) provided the first $500,000 in seed capital to create the loan fund's capital pool. In 2005, LPFA provided a second $300,000 10 year no interest loan from the Louisiana Public Facilities Authority (LPFA). RWJF provided a $500,000 grant to the capital fund in 2005.

To secure the seed capital grant, SELAHEC developed credible plan to leverage private and/or public resources, resulting in a minimum of $3 million in loans by the end of the grant period. SELAHEC also secured a minimum of $200,000 in cash resources as additional seed capital.

Although loan fund programs in each of the three states have different developmental histories, Arkansas, Louisiana, and Mississippi Loan Fund models are sufficiently mature to serve as useful examples for federal and state policy makers and private funders to consider replicating.

Program: ***Enterprise Corporation of the Delta***
Strategy: ***Economic Development***
Focus: ***Health Infrastructure Capacity Development***
Population: ***Public and Private Health Providers***

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Project Description: The Enterprise Corporation of the Delta is a non-profit, community development financial institution with 10 years of experience in commercial lending in distressed communities in Mississippi, Arkansas, and Louisiana. As one of the nation's leading community development financial institutions, ECD has a mission to improve the quality of life for low- and moderate-income residents of Arkansas, Louisiana, and Mississippi by providing market –driven financial and technical assistance to firms, entrepreneurs and homeowners; forging strategic partnerships with the private, public an not-for-profit sectors; and otherwise promoting the development of the region's human and economic assets.

In 2001, ECD became involved with the Robert Wood Johnson Foundation (RWJF) Rural Loan Fund Program through the Mississippi Access for Rural Care (MARC) Program. MARC was established through the Southern Rural Access Program, funded by the RWJF. Although health was among the sectors targeted by ECD as critical to the region's economic development, the partnership through MARC provided additional resources and focus in this area.

Project Activities: While ECD's core programs focus on business development, the organization also works to strengthen communities, build assets and improve the lives of people in economically distressed areas of Arkansas, Louisiana, and Mississippi. With additional support from the RWJF, ECD will continue to expand its health care lending in the Mid South. The source of most loan requests in coming years is anticipated to continue to be rural health centers and hospitals that lack access to financing for fixed assets but that have an established flow of working capital. Capital will be used for renovation of existing facilities, construction of new facilities, bridge loans, and medical equipment upgrades.

ECD provides technical assistance to rural hospitals, rural health centers, and primary care providers to prepare them for capital projects. They provide training programs that

prepare residents for jobs in the health services sector; and pursue policy collaborations that promote expanded access to health insurance for children and low-income workers.

Project Impact: Since 2001, ECD has leveraged RWJF funding to secure matching private capital and public credit enhancement programs for health projects. ECD has committed to finance $7.5 million in loans to health care facilities. As evidenced by over $150 million in financing generated and 10,000 beneficiaries of its work, ECD has a solid record of building and managing development finance programs.

Program: ***Mississippi Shine Project***
Strategy: ***Community Coalition and Network Development, Leadership Development***
Focus: ***Community Health Systems Development***
Population: ***Public and Private Health Providers***

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Project Description: The Mississippi (MS) Shine Project is a statewide program that seeks to make improvements in citizens' health status in 41 counties in Mississippi. MS Shine has created a statewide consortium that includes the Aaron E. Henry Community Health Center, the MS Primary Care Association, the MS Hospital Association, and the MS AHEC program. The Advisory Board includes members from the MS Department of Health, the MS State Office of Rural Health, the MS State University, the Delta State University, Alcorn State University, the Delta Health Alliance, and the Delta AHEC.

MS Shine seeks to impact health through the provision of community-based initiatives. The statewide consortium conducted a needs assessment in 2003 to determine the priorities for the community initiatives. According to the needs assessment, obesity, cardiovascular disease, diabetes, teen sexual activity and pregnancy, substance abuse, and lack of physical activity were the areas of highest need.

Project Activities: The MS Shine's central administrative role is to provide membership, governance, and participation guidelines for network participants. They also provide training in program development, organizational development, and leadership development to facilitate the local network's success. The MS Shine Project consists of nine community health networks that have identified priorities from the above lists as follows:

The Kudzu Delta Health Network services Benton, Tippah, Union and Lafayette counties, and focuses on obesity, cardiovascular disease, and diabetes. They conduct community health fairs providing free and comprehensive health screenings.

The Western Hills Health Partnership services Marshall, Tate, Panola, Yalobusha, Tallahatchie, and Grenada counties, and focuses on all 5 MS Shine areas. Program examples include "90 Days Towards Fitness for Life," and diabetes support groups.

The Deporres Health Network services Tunica, Coahoma, and Quitman counties with focus areas of obesity and related chronic diseases. Programs include nutrition education and free community exercise classes.

The Delta Diamond Rural Development Network services Bolivar, Washington, Sunflower, and Leflore counties and focuses on all five MS Shine concerns. Their programs include community health fairs and CHIP outreach activities in local schools.

The Central MS Rural Development Network services Carrol, Montgomery, Holmes, Attala counties and focuses on all five MS Shine concerns. Program examples include LifeSmart Camp and community health fairs.

The Humphreys County Memorial Hospital services Humphreys, Sharkey, Issaquena, and Yazoo counties and focuses obesity, cardiovascular disease, diabetes, and asthma. The current program example includes Lunch and Learn Asthma Education.

The Southwest Quadrant Health Network services Warren, Claiborne, Jefferson, Adams, Franklin, and Wilkinson counties. Health focus areas include all five SHINE concerns. Program examples include "Scared Straight," community health fairs, and free aerobic classes.

The Teen Health Network services Copiah, Lawerence, Simpson, and Covington counties, and focuses on teen pregnancy prevention and juvenile diabetes. Program examples are abstinence and sexually transmitted disease education in area schools and churches. The program reaches over 5000 adolescents.

The Southwest Mississippi Opportunity serves Lincoln, Pike, and Amite counties. The health focus is still to be determined.

Target Population: MS Shine services the citizens of 41 Mississippi Delta counties.

Project Time Frame: MS Shine began in 2001 and remains in effect.

Project Staff: The central administrative staff includes a Program Director and the local networks are coordinated by Community Encouragers.

Funding: MS Shine is one of eight states participating in the Delta States Networking program funded by the National Office of Rural Health Policy, Health Resources Services Administration. The program is funded at approximately $1 million annually.

Program: ***Better Health for the Delta***
Strategy: ***Community Coalition and Network Development, Leadership Development***
Focus: ***Community Health Systems Development***
Population: ***Public and Private Health Providers***

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Program Description: The Better Health for the Delta (BHD) program provides a range of technical assistance and program development services to support community organizations in the development and implementation of projects to address unmet health care needs, to expand the delivery, and to promote the sustainability of health care services in rural communities. The program office initially provided technical assistance to community leaders on how to establish community coalitions, conduct community needs assessment, and prioritize needs and interventions. As communities progressed, technical assistance was re-focused on project planning and implementation.

The BHD program fosters improvements in health status, financial viability and access to care through the development of local and regional coalitions and network structures that are closely linked to local providers and community needs and capacities. The BHD program has also focused on innovation, social entrepreneurship and community leadership. Each community coalition is led by a "community encourager," a community individual who is a "connector," someone who can bring various community resources to the table to work toward the community good.

Project Activities and Outcomes: Depending upon the needs assessment activities, Louisiana communities are focusing on a variety of projects including pharmacy access, transportation, dental health improvement, teen pregnancy prevention, community wellness centers, and mental health expansion. Of the 29 eligible parishes, 23 parishes participated during phase I of the program, which focused on individual parish coalition development. A second phase was initiated in 2004 which is focused on the development of six regional coalitions.

Target Population: Twenty-nine rural Louisiana Parishes are included in the Better Health for the Delta service area. The area had a population of 773,338 prior to Katrina.

Program Dates: The project began it first three-year phase during 2001. The second phase began in 2004.

Project Staffing: During Phase I, local coalitions had to employ a part-time Community Encourager. Central administrative staff included a program director (.5 FTE), deputy director (.5 FTE), program coordinator (.5 FTE), and an administrative assistant (.5 FTE). Phase II grants are organized so that each multi-parish network can employ a full-time coordinator.

Project Budget: During Phase I, each parish received $17,000 annually for three years. During Phase II, multi-parish clusters receive $96,000 annually.

Source of Funding: The Federal Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy provides the major funding, although communities have leverages substantial matching funds.

Program: ***The Lincoln Parish Health Coalition***
Better Health for the Delta Phase I
Strategy: ***Population Based Risk Reduction***
Focus: ***Wellness***
Population: ***African American Church Members***

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Project Description: The Lincoln Parish Health Coalition (LPHC) began with a three-year planning grant designed to mobilize Lincoln Parish leadership to enhance health status and overall quality of life of its residents. Initiated in March 2004, this project used a needs assessment and public awareness campaign as baseline efforts to both gather health status data and inform and educate the public about the health risks of obesity and cardiovascular disease. Town leaders were recruited to participate in a comprehensive needs assessment project to identify the determinants of health. Public forums were held to gain input from health agencies, faith-based agencies as well as the general public regarding barriers to health. From the results of the needs assessment and focus group meetings, stakeholders selected and prioritized programs that have proven to be successful.

This project has developed a coalition that includes the Lincoln Parish Health Unit, Lincoln General Hospital, Ruston Interdenominational Alliance of Ministers (IAM), Humanitarian Enterprise of Lincoln Parish (HELP), the Ministerial of Alliance of Grambling LA, the Lincoln Parish Police Jury, and New Living Word Ministries (NLWM).

The needs assessment indicated that one in five of Lincoln Parish residents are uninsured, and that rates of obesity and tobacco use are high. Poverty and lack of education are barriers to health improvements in Lincoln parish, as is generally true of the entire state. Despite this obstacle, the LPHC is making significant progress through our collaborative efforts to reduce health disparities.

Long Term Goals: The goal of the LPHC is to serve the target population that is at risk for lifestyle-related behavioral diseases through health education and preventive services such as health fairs, family life centers and public health awareness campaigns. The project will support the mindset of self-help. Individuals are being empowered to identify their

health needs and are being encouraged to act on an understanding of the importance of healthy lifestyle. Objectives include the following:

1. Develop a local provider network that will coordinate a parish-wide planning process (service inventory of provider network).
2. Identify the community health needs, as well as barriers and factors that facilitate assess to services.
3. Assess current services regarding cultural sensitivity and relevance.
4. Expand the awareness of the roles and benefits of local health networks, as well as develop and field-test low-cost preventive health care programs.

Project Activities:

Transportation. A key focus of the coalition efforts is increasing public awareness (health campaign) regarding perception of the Public Transportation System in Lincoln Parish administered through the Police Jury and the Humanitarian Enterprise of Lincoln Parish (HELP). Many of the residents of Lincoln Parish have the perception that the transportation program only assists those that need medical attention and the coalition is assisting HELP in changing that perception.

Resource Directory. A community resource directory for local residents of Lincoln Parish is being developed through a partnership between the Partners in Prevention grant at Louisiana Tech University, the United Way, and the local newspaper. Both a printed and an online version will be published and will be updated through United Way.

Prescription Assistance Project. We are increasing public awareness of a SeniorRX program that is being administered out of Monroe, for low-income individuals, primarily those who are African American.

Family Life Centers, Faith-Based Health Promotion and Disease Prevention. Lincoln Parish now has two newly constructed family life centers that provide recreational, leisure time, and sport activities for the residents of the community. New Living Word Ministries (NLWM) includes a health awareness section in their quarterly newsletter that is distributed to the congregation. One of center's health programs is the (M.O.V.E.) Boys Basketball League for sixth- and ninth-grade boys. There is increasing interests in an activity for girls of the same grade levels. The parents of the youth are given health awareness messages during half-time of the games. An adult fitness challenge is scheduled to begin at the start of the New Year. In addition, a senior citizens' monthly bingo has been initiated to provide elders with an activity away from their assisted living facilities and homes. Health awareness seminars and health fairs are being conducted in local churches and in the new

Family Life Centers. Ministers from the area are being encouraged to join the movement and start health programs in their churches. A third Family Life Center has just broken ground, and a fourth and fifth are in planning.

Target Population Served: The project serves Lincoln Parish with emphasis in the Ruston and Grambling communities. Lincoln Parish's population is 42,173 (2000 U. S. Census), 40 percent of whom are African American. The population that we are serving consists of rural residents with varying levels of educational attainment. Despite the fact that two higher education institutions (Grambling State University and Louisiana Tech University) are in the area, more than 20 percent of the population does not have a high school diploma. These communities are located in North Central Louisiana where more than 25 percent of the population lives in poverty. The leading causes of death in the targeted population are heart disease, diabetes, and stroke, all of which are aggravated by obesity. The population that we are serving consists of rural residents with varying levels of educational attainment.

Description of Geographic Area. Lincoln Parish is 471 square miles with a population of 42,173, which includes student populations of two four-year universities, Grambling State University and Louisiana Tech University. Ruston is the parish seat with a population of 31,308. Grambling city has a population of 2,616. Health-related services are provided by the Lincoln Parish Health Department, Lincoln General Hospital and Lincoln Parish School System, as well as other primary care physicians. However, the services available are under utilized and poorly coordinated. Currently, most clinics accept new patients and Medicaid. The problem stems from lack of awareness of symptoms of various diseases and getting patients to utilize and access available primary care and preventive care services. Also, the target population has a history of mistrust and recognition of disparity in treatment by the local health care. The LPHC is seeking to educate those who are typically underserved and trying to mend some of the historical wounds that have led to the negative perceptions that many residents have about local health care agencies.

Number of People Served or Impacted by the Project: The program seeks the involvement of local business owners and civic organizations. Over 3,000 children and families have received either health awareness information through 10 seminars and two health fairs, numerous recreational activities for youth and the program is being reinforced by a media campaign. The role of Louisiana Tech University as the lead agency in the current proposal (Better Health for the Delta) has been to develop a coalition of interested stakeholders with the sole purpose of enhancing the health and quality of life of Lincoln

parish residents. Through a public awareness campaign town leaders have been recruited to participate in this comprehensive needs assessment project that identifies the determinants of health in Lincoln parish. From the results of the needs assessment, involved parties have selected and prioritized programs that have proven to be successful in similar populations and environments.

Operational Period and Dates of the Project: The term of this grant began June 1, 2004 and will continue through May 31, 2006. The LPHC plans to continue activities beyond the planning grant, and is seeking additional grant funds.

Project Staffing: Lincoln Parish Health Coalition (LPHC): The program is staffed by a part time coordinator, inkind administrative support from two assistants, and at least five community volunteers.

Project Funding: The project has been funded at $17,000 annually for three years, and has received substantial inkind support from New Living Word Ministries, Lincoln General Hospital, Humanitarian Enterprises of Lincoln Parish and Louisiana Tech.

Program: ***The RWJF Southern Rural Access Program***
Strategy: ***Healthcare Capacity and Infrastructure Improvement***
Focus: ***Primary Care***
Population: ***Selected Parishes and Counties in the Rural South***

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Project Description: The Southern Rural Access Program (SRAP) is designed to help improve access to basic healthcare in eight of the most rural, medically underserved states in the country. The program supports work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure and build capacity at the state and community level to address healthcare problems. To achieve these goals the program focuses on rural health leadership development; recruitment and retention of primary healthcare providers; rural health network development; and revolving loan fund development.

Project Funding: The SRAP is funded by The Robert Wood Johnson Foundation and administered by the Penn State College of Medicine. The National Project Director is Michael Beachler (717) 531-2090. The Foundation has awarded $32.8 million to date for grant making, technical assistance, administration and program evaluation for this effort to improve access to care in Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas and West Virginia. The programs for Arkansas, Louisiana, and Mississippi are profiled below.

ARKANSAS

Program Description: The Arkansas Center for Health Improvement (ACHI), an organization created with resources from the Winthrop Rockefeller Charitable Trust, the University of Arkansas for Medical Sciences (UAMS), the Arkansas Department of Health

and the Arkansas Community Foundation resources, will provides leadership for the Arkansas effort. Kate Stewart, MD, MPH is the project director (501-660-7586).

Rural Health Leaders. During the current funding period, a part-time primary care physician mentors primary care residents and medical students on a biweekly schedule to nurture rural interest and counsel the students about practice decisions. Since SRAP funding began for this initiative, 58 residents and 21 medical students have been precept in rural health issues and topics by Larry Braden, MD, physician mentor. In addition to the direct preceptorship benefits, this program has improved communications about Arkansas's Community Match and Rural Loan and Scholarship Programs.

Recruitment and Retention. The Delta recruiters offer communities and medical providers much needed technical assistance in community development; medical staff planning; and recruitment and retention of primary care providers. The Delta program recruiter has already placed 11 healthcare providers in rural communities. Based on prior activity it is anticipated that another 14 providers will be recruited to the region in this two-year grant period. Funding will continue to support the effort of a recruiter in the northern portion of the Delta and one in the Southern portion of the Delta.

In addition to the work of the Delta recruiters, the use of a practice management (PM) coordinator has proven successful in helping providers maintain viable rural practices through targeted interventions. Previously, the project employed one coordinator who worked in cooperation with the Arkansas Medical Society to provide practice evaluation and improvement planning to rural physicians. The coordinator addressed both fiscal issues (billing, coding and revenue reimbursement maximization) and practice efficiency issues (patient flow, scheduling, customer-oriented service and corporate compliance).

The coordinator's efforts resulted in 13 initial practice assessments and 13 follow-up visits. The current goal is to provide PM services to at least 10 new practices in each of the next two years. This goal will be achieved with the addition of a second practice management coordinator who will work in conjunction with the Community Health Centers of Arkansas to provide technical assistance to community health centers and prospective federally qualified health clinics.

Rural Health Networks. Three new networks were formally organized and began implementing defined program interventions through the assistance of the community development technical specialist. Two other networks started in Phase I of SRAP achieved full sustainability. Through the work of the specialist, approximately $1.7 million of funds were secured from a variety of health and healthcare-related efforts to help over 20

communities in the target region. During this funding period, the specialist will work on bringing two implementation-phase networks and two new networks to sustainability over the next two years. Previously, the specialist provided service to a broader region. However, in this round the specialist will focus more narrowly on the targeted networks with intensive technical assistance to identify and secure resources.

In addition, a network development consultant will be retained to provide technical assistance to targeted networks developed through HRSA's Arkansas Delta Rural Development Network Program in partnership with the Mid-Delta Community Consortium.

Revolving Loan Fund. The Arkansas Revolving Loan Fund, the first SRAP loan fund to receive a seed capital grant from the Robert Wood Johnson Foundation, was awarded its first $500,000 grant in 1999. In April 2002, a second seed grant of $500,000 was awarded based on the loan fund's successful track record of closing millions of dollars in loans. Through leveraging of this last grant Southern Financial Partners made eight loans totaling $1,175,963 in the target region.

In the current grant cycle, funds were allocated to match resources from Southern Financial Partner, the Fund's agency home, to hire a capital development officer. It is anticipated that the capital development officer will raise one million dollars in new capital during this two-year grant period.

Target Region: 14 counties in the Arkansas Delta encompassing a population of nearly 318,000 are the target areas. Specific counties include Arkansas, Ashley, Chicot, Crittenden, Cross, Desha, Drew, Lee, Lincoln, Mississippi, Monroe, Phillips, St. Francis and Woodruff.

Funding: The most recent round of funding is $754,286 for 24 months (4/1/04-3/31/06).

LOUISIANA

Program Description. The Louisiana State University Health Sciences Center, School of Public Health (LSUSPH) provides the leadership for the Louisiana Rural Health Access Program (LRHAP). The LSUSPH was established in July 2003 with the mission of improving the health of people in Louisiana though education, research and community service. A special emphasis is placed on the health and healthcare of underserved people. The Bureau of Primary Care and Rural Health, a division of the Louisiana Department of Health and Hospitals, is a key partner in this initiative. In addition, a Partners Technical Assistance Board comprised of 12-25 organizational representatives participate in discussion

of key program issues. The project director is Marsha Broussard, MPH and her contact information is (504-491-4420).

Program Activities:

Recruitment and Retention. In Louisiana, regionally based direct provider recruitment services did not exist before the implementation of the LRHAP. Within the first nine months of the hiring of the state's first healthcare recruiter in 2002, three new providers were hired in the LRHAP pilot region. The early success of this effort combined with the renewed rural focus of the Bureau of Primary Care and Rural Health led to efforts to expand the program.

The expansion of Practice Sights was the catalyst for integrating existing recruitment programs offered by Central, North and South West AHECs, the Medical Job Fair, Med Job Louisiana, loan repayment and J-1 Visa programs offered by the Bureau of Primary Care and Rural Health. As a result of this integration, there are now recruiters serving both southern Louisiana (partially funded by LRHAP funds) and northern Louisiana (totally supported by state funds) and the new statewide recruitment and retention program assumed the name, Med Job Louisiana.

Practice Management. The La. Bureau of Primary Care and Rural Health partners to provide practice management (PM) services. A PM coordinator focuses on providing PM services to rural health clinics (including assisting with obtaining rural health clinic certification), federally qualified health centers and private practices. LRHAP funds support staff and consultant costs.

In addition to specialized and tailored services to rural providers, PM activities include hosting billing and reimbursement workshops for rural health clinics, hospitals, FQHCs, and private providers. The staff also developed a Rural Health Clinic Manual that explains regulatory requirements and reimbursements. The long-term goal is to improve the fiscal viability of primary providers by equipping them with the tools they need to realize higher revenues.

Rural Health Networks. Since the inception of LRHAP, community health networks were developed in Vermilion, Iberia and St. Landry Parishes and substantial technical assistance was provided to previously existing networks in St. Mary and Allen Parishes. A noteworthy result is that several of these networks have received grant resources totally around one million dollars from federal, state and philanthropic resources to initiate new services in underserved rural communities.

Current efforts are being concentrated on bringing these parish level networks together to work on a regional network program. LRHAP funds will provide partial support for a community network development director and a pharmacy access network coordinator. A regional pharmacy access program has been identified as an area of collaboration for the existing networks. To achieve this goal a regional planning forum will be held to explore the best way to proceed in expanding and strengthening the existing programs.

Revolving Loan Fund Program. At the inception of the Louisiana Revolving Loan Fund the Louisiana Public Health Institute (LPHI) was the fiduciary agent and the South East Louisiana Area Health Education Center (SELAHEC) housed the two administrative staff. In 2003, all responsibilities were moved to SELAHEC.

The loan fund made significant progress in 2003 when it successfully applied for a $500,000 seed capital grant from RWJF. In addition, the loan fund leveraged an additional $300,000 in zero interest funds from the Louisiana Public Facilities Authority and $37,000 from the Bureau of Primary Care and Rural Health to supplement administrative costs. Since its inception the loan fund has made and/or facilitated four million dollars in direct or subordinated loans. LRHAP funds will provide partial support for a senior loan coordinator, a senior loan development specialist and a new part time loan coordinator. With the new funding it's anticipated that six million dollars in new loans will be developed to improve access to primary care in rural Louisiana. The Louisiana Rural Loan Fund Program is also featured separately as a promising practice.

Target Region. 14 parishes in south central and west Louisiana encompassing a population of over 580,000. Specific parishes include Acadia, Allen, Assumption, Beauregard, Cameron, Jefferson Davis, Evangeline, Iberia, Iberville, Pointe Coupee, St. Landry, St. Mary, St. Martin and Vermilion.

Funding. The current level of funding is $850,315 for 24 months (4/01/04 – 3/31/06).

MISSISSIPPI:

The Mississippi Primary Health Care Association, representing 21 community health centers and other community-based primary health care organizations, provides leadership for Mississippi's Rural Access for Care (MARC) Program. The project director Marcus Garner (601-355-7226)

Program Description:

Rural Health Leaders. The MARC Medical Enrichment and Development (MMED) will continue at its two existing sites, Coahoma Community College and Copiah-Lincoln Community College. The long-term goal of the program is to increase the number of students choosing to practice in rural Mississippi as a result of being exposed to a program that emphasizes the significant healthcare needs of the rural areas. A workforce development coordinator, partially funded by RWJF, oversees and manages this program. The Mississippi Area Health Education Center Program provides matching funding.

MMED is a six-week medical enrichment program that provides didactic sessions and primary care clinical exposure to minority and disadvantaged college level students from rural areas in Mississippi. Forty-five students participated in this program during the last grant period and it is anticipated that 48 students will participate in MMED over the next two years. The program is offered in two parts – MMED I for sophomore-level students and MMED II for those who have completed MMED 1. The program provides opportunities to increase the student's chances of being accepted into health professional schools. Specifically, MMED I offers sessions geared toward improving student's math and science proficiency along with test taking and reasoning skills; exposes students to rural clinical practices; and requires completion of a research assignment that addresses health disparities and needs in their placement site or the community at large. MMED II expands on MMED I by providing more in-depth course work specific to students' areas of interest and offering longer clinical experiences.

Recruitment and Retention. Through the work of a recruitment administrator MARC's recruitment and retention strategies include recruiting and retaining licensed primary care providers to underserved rural areas of the state and tracking students throughout their professional training.

In the last grant period the recruiter administrator was successful in placing 31 health professionals in rural underserved areas. This included the successful recruitment of 11 American born health professionals, seven of whom were placed in the MARC target region. The recruiter administrator also provided technical assistance to rural facilities with the

placement of 20 J-1 Visa, internationally trained physicians. Staff also provided research to help improve policy on financial incentives to health professional students and residents by reducing the time of service obligations for the state's loan forgiveness and scholarship programs.

Future plans for the recruiter administrator include enhancing and marketing the state's loan repayment program; recruiting Mississippi residents enrolled at out-of-state medical schools and residency programs; and incorporating the federal clinical/non-clinical staff rural recruitment and retention program with the RWJF supported recruitment and retention program.

The Mississippi Hospital Association-led practice management component will continue to provide technical assistance to healthcare facilities on issues such as human resources, reimbursement, coding, collections and clinical operations. In the last funding cycle 38 rural healthcare facilities were assisted through this service. Staff from the practice management service also played a key leadership role in the development of the first billing and coding curriculum ever offered at two Mississippi community colleges.

It is expected that at least 40 facilities will be helped in the next two-year phase as a result of the work of the SRAP-approved coding specialist and practice management coordinator. The Mississippi Hospital Association completely funds a third practice management coordinator. It is also anticipated that 80% of these facilities will experience revenue increases or other types of business enhancements.

Rural Health Networks. Staff from the Mississippi Primary Health Care Association (MPHCA) will have an important technical assistance role in the Office of Rural Health Policy's Delta States Rural Development Network Program. MPHCA staff will provide technical assistance to community coalitions and networks supported by the federally funded program.

Revolving Loan Fund. Mississippi's revolving loan fund is funded through a separate grant from RWJF and administered by the Economic Corporation of the Delta (ECD). As of April 2004, ECD has closed $2.3 million in loans. ECD's loan review committee has approved an additional $1.4 million in loans. To enhance the activities of the loan fund, funds in this grant will be used to partially support a loan credit analyst specialist. The credit analyst specialist will have primary staff responsibility for analyzing and underwriting health care loans. The ECD is a focused as a separate promising practice.

Target Region: 31 counties in the northwest (Delta) and southwest parts of the state encompassing a population of over 690,000. Specific counties include Adams, Amite, Attala, Bolivar, Carroll, Claiborne, Coahoma, Copiah, Franklin, Grenada, Holmes, Humphreys, Issaquena, Jefferson, Lawrence, Leflore, Lincoln, Montgomery, Panola, Pike, Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, Walthall, Warren, Washington, Wilkinson, Yalobusha and Yazoo

Funding: Funding for the current program period is $767,488 for 24 months (4/1/04-3/31/06).

Appendix

Outline:

A. Description of the Foundation of the Mid South

B. Description of the Robert Wood Johnson Foundation

C. Task Force Members

D. Project Team

The Foundation of the Mid South

The Foundation for the Mid South invests in people and strategies that build philanthropy and promote racial, social, and economic equity in Arkansas, Louisiana, and Mississippi.

The Foundation for the Mid South is a regional development foundation that brings people together, strengthens communities, and multiplies resources. By working with people with a wide range of resources, skills, and talents, the Foundation for the Mid South strives to nurture families and children, improve schools, and build the economy for all people in Arkansas, Louisiana, and Mississippi.

The three states of Arkansas, Louisiana, and Mississippi continue to rank at the bottom in measures of opportunity and quality of life. The people and partners of the Foundation understand the need to build the nonprofit sector in the Mid South where poverty is the highest.

The Foundation for the Mid South is the only organization serving the Mid South that provides the leadership and the resources to achieve this vision. Over the past ten years, the total impact of the Foundation's programs is estimated at $150 million in new resources for the region.

The Foundation for the Mid South works to build the communities resources and leadership of Arkansas, Louisiana, and Mississippi through change strategies based on regional cooperation. It does so by using private philanthropic resources to fund, develop, and promote programs in focused areas. Our current areas of interest including **education**, **economic development**, and **families and children**.

In each of these areas, the Foundation for the Mid South makes grants, hosts training sessions and seminars, provides technical assistance, and brings people and organizations together to form networks, collaborations, and partnerships throughout the region.

- The Foundation for the Mid South was created in 1989 by former Mississippi Governor William Winter, former CEO of Entergy Corporation Edwin Lupberger from Louisiana, and Bob Nash of Arkansas to capitalize on the growing spirit of regional cooperation between the three states.
- The Foundation published *Where Hope and History Rhyme: The Reflections and Findings from the Mid South Commission to Build Philanthropy* in January 2005 after conducting a two year effort to study the relationship between philanthropy and racial and social equity and how to develop community wealth.

The Robert Wood Johnson Foundation

The Mission
The Robert Wood Johnson Foundation seeks to improve the health and health care of all Americans. To achieve the most impact with our funds, they prioritize grants into four goal areas:

To assure that all Americans have access to quality health care at reasonable cost.

Nearly 45 million Americans, over 8 million of them children, go without health insurance. This is the single greatest barrier to obtaining timely, appropriate health care services.

To improve the quality of care and support for people with chronic health conditions.

One hundred million Americans suffer from chronic health conditions, and that number is almost certain to increase as the population ages.

To promote healthy communities and lifestyles.

Our health behaviors, level of social interaction, and other factors outside medical care are important influences on overall health.

To reduce the personal, social and economic harm caused by substance abuse—tobacco, alcohol and illicit drugs.

Tobacco, alcohol and illicit drugs inflict an enormous toll on Americans, especially among our youth.

To accomplish these goals, the RWJF uses a variety of strategies. They support training, education, research (excluding biomedical research), and projects that demonstrate the effective delivery of health care services. Rather than paying for individual care, they concentrate on health care systems and the conditions that promote better health.

Grantees are as varied as the challenges they tackle. They include: hospitals; medical, nursing, and public schools; hospices; professional associations; research organizations; state and local government agencies; and community groups.

The rich history of the Foundation began with the founder, Robert Wood Johnson.

Robert Wood Johnson devoted his life to public service and to building the small, but innovative, family firm of Johnson & Johnson into the world's largest health and medical care products conglomerate.

His interest in hospitals led him to conclude that hospital administrators needed specialized training. So he joined with Dr. Malcolm Thomas MacEachern, then president of the American College of Surgeons, in a movement that led to the founding at Northwestern University of one of the first schools of hospital administration.

General Johnson also had an intense concern for the hospital patient whom he saw as being lost in the often bewildering world of medical care. He strongly advocated improved education for both doctors and nurses, and he admired a keen medical mind that also was linked to a caring heart. His philosophy of corporate responsibility

received its most enduring expression in his one-page management credo for Johnson & Johnson. It declares a company's first responsibility to be to its customers, followed by its workers, management, community and stockholders—in that order.

Robert Wood Johnson's sense of personal responsibility toward society was expressed imperishably in the disposition of his own immense fortune. He left virtually all of it to the foundation that bears his name, creating one of the world's largest private philanthropies.

The Southern Rural Access Program

In 1998, RWJF initiated the Southern Rural Access Program (SRAP) as a long-term effort to build the institutional and leadership capacity to improve access to basic healthcare in eight of the nation's most rural, medically underserved areas. The Arkansas, Louisiana, and Mississippi are among the eight target states. This program was established on the premise that regional clusters of states are more likely to learn from each other and that no single intervention by itself is likely to significantly improve access to care. The potential impact of layering multiple promising practices led to the development of a multi-faceted approach. The programs for Arkansas, Mississippi and Louisiana are described in more detail in this report in the section, Promising Practices, found on pages 65 through 72.

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The Project Team:

The Southern Regional Health Consortium:
The Project Team was assembled by the Southern Regional Health Consortium (SRHC). Established in 2004, the SRHC is committed to developing a cadre of health professionals who are dedicated to solving problems contributing to access to health care among its eight member states. SHRC has further committed to identifying, quantifying and articulating the root causes of the South's poor health status and seeking solutions to address them. Through regional collaboration, SHRC promotes sharing of lessons learned across states. A regional approach will provided the opportunity for states with similar demographics and challenges to learn from each other's experiences. www.shrc.info

Marsha Broussard, MPH is the Director of the Resource Center for Rural and Community Health Improvement, Louisiana State University (LSU) School of Public Health. She is the principal of the project, and is a founding member of the SRHC. She is the principal author of this Resource Report. More information can be obtained about M. Broussard at www.laruralhealth.com .

Members of the Project Team will be available at the January 9-10 meeting to facilitate discussions, and answer questions.

Connie Baird-Thomas, PhD. is the Associate Director of the Social Science Research Center for Policy Studies and Director of the Mississippi Health Policy Research Center (a division of the Social Science Research Center (SSRC)). She is a Research Fellow and Assistant Professor at Mississippi State University. Connie Baird identified Promising Practices for the State of Mississippi, and developed the contact list. http://www.healthpolicy.msstate.edu/

Nancy Dockter, is a staff member with the Fay W. Boozman, College of Public Health, University of Arkansas Medical Sciences (UAMS). Nancy Dockter profiled Promising Practices from the State of Arkansas and developed the contact list for the January convening.

Holly Felix, PhD, MPA is an instructor and Project Director with the Fay W. Boozman, College of Public Health, UAMS. Holly Felix compiled health related data for the three states that was used to develop the Resource Report maps and developed the contact list for the January 2006 convening.

Sandy Johnson, PhD is an Epidemiologist, and Assistant Professor at the LSU School of Public Health. Sandy Johnson, a medical geographer, developed the maps included in the Resource Report.

Shahalynni (Holly) Jones, BS Biology is a Research Assistant for the Resource Center for Rural and Community Health Improvement, LSU School of Public Health. Holly Jones coordinated the development of the list for the January convening, and assisted with research and project logistics.

Ruth Landis, BCSW is the Project Coordinator of Resource Center for Rural and Community Health Improvement, LSU School of Public Health. Ruth Landis coordinated the collection of Promising Practices.

Kate Stewart, MD, MPH is an Associate Professor in the UAMS. She is the Director of the Office of Community Based Public Health in the Fay W. Boozman College of Public Health. Kate Stewart coordinated the project activities from UAMS. http://www.uams.edu/coph/community/

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